TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS

FINAL STATEMENT OF REASONS

Subject Matter of Regulations: Workers' Compensation Qualified Medical Evaluator Regulations

TITLE 8. CALIFORNIA CODE OF REGULATIONS SECTIONS 1 - 159

Title 8, California Code of Regulations, sections 1 - 159.

The Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 133, 139.2, and 5307.3, has adopted, amended and repealed regulations within Articles 1 through 15, Chapter 1 of Title 8, California Code of Regulations, commencing with section 1, relating to the Qualified Medical Evaluator regulations.

UPDATE OF INITIAL STATEMENT OF REASONS

As authorized by Government Code §11346.9(d), the Acting Administrative Director (hereafter, Administrative Director) hereby incorporates by reference the entire Initial Statement of Reasons prepared in this matter. Unless a specific basis is stated below for any modification to the regulations as initially proposed, the necessity for the amendments to existing regulations and for the adoption of new regulations as set forth in the Initial Statement of Reasons continues to apply to the regulations as now adopted.

All modifications from the initially proposed text of the regulations are summarized below.

THE FOLLOWING SUBDIVISIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND CIRCULATED FOR A 15-DAY COMMENT PERIOD:

ARTICLE 1. GENERAL

§ 1. Definitions

The following modifications were made in response to comments received.

§ 1(d). "Agreed Panel QME":
A new definition for "Agreed Panel QME" was added as subdivision 1(d). The term means "…the Qualified Medical Evaluator described in Labor Code section 4062.2(c), that the claims administrator, or if none the employer, and a represented employee agree upon and select from a QME panel list issued by the Medical Director without using the striking process. An Agreed Panel QME shall be entitled to be paid at the same rate as an Agreed Medical Evaluator under section 9795 of Title 8 of the California Code of Regulations for medical/legal evaluation procedures and medical testimony."

This change is necessary to distinguish the QME which represented parties agree upon pursuant to Labor Code section 4062.2(c) and to make clear the Administrative Director's intention that such an Agreed Panel QME be reimbursed and afforded the same formalities as Agreed Medical Evaluators. The Legislature established this new category of agreed medical evaluator selected from a QME panel list by the wording in Labor Code section 4062.2(c) as enacted in SB 899.

Other subdivisions of section 1 have been re-lettered accordingly.

§ 1(f). "AME":
The phrase "…claims administrator, or if none the…" was inserted before the word "employer" in the existing regulation for clarity and consistency. While the Labor Code uses the word "employer" throughout the relevant sections describing the role and functions of Agreed Medical Evaluators (AMEs), generally the employer has a claims administrator performing those functions for the employer.

§ 1(g). "AOE/COE":
This definition has been deleted in its entirety, and the subsequent subdivisions of section 1 have been re-lettered, accordingly.

This definition was deleted because it is unnecessary, since the text using this term in sections 1 through 159 of Title 8 of the California Code of Regulations proposed in an earlier version of the draft regulations, was deleted.

§ 1(k). "Claims Administrator":
Subdivision 1(k) "Claims Administrator" was amended to add the phrase "any of the following" after the words "person or entity responsible for the payment of compensation for" and also to add the following identifiers to the list of persons or entities for which the claims administrator pays compensation: "an insured employer", " and for the Subsequent Injuries Benefit Trust Fund (SIBTF)" and "the California Insurance Guarantee Association (CIGA)". This additional wording was necessary for clarity in describing both the function of the claims administrator and the various entities with liability to provide such workers' compensation benefits to an injured employee.

§ 1(s). "Evaluator":
Subdivision 1(s) "Evaluator" has been amended to add the phrase "any of the following:" and to add to the list of identifiers: "Agreed Panel QME" or "Panel QME", as appropriate in a specific case." This additional wording is necessary for clarity and consistency with other definitions and terms used in the regulations and the Labor Code.

§ 1(v). "Medical Director":
Subdivision 1(v) "Medical Director" was amended to read: "and includes any Associate Medical Directors when acting as his or her designee." This additional phrase is needed for clarity to ensure that Associate Medical Directors who are designated by the Medical Director to act as a designee do so with the full authority of the Medical Director.

§ 1(w). "Mental health record":

A new definition, "Mental health record" was added and means "…a medical treatment or evaluation record created or reviewed by a licensed physician as defined in Labor Code section 3209.3 in the course of treating or evaluating a mental disorder." This new definition was needed for clarity and consistency due to use of this term in regulatory language added in section 36.5 of Title 8 of the California Code of Regulations. This section directs evaluators and parties regarding medical records and reports in the workers' compensation system that may be subject to a medical finding under Health and Safety Code section 123115(b). Such a finding by a physician requires that such records not be provided directly to the patient or injured employee about whom the records pertains.

Other subdivisions of section 1 were re-lettered accordingly.

§ 1(x). "Panel QME""

A new definition, "Panel QME", was added and means, "…the physician, from a QME panel list provided by the Medical Director, who is selected under Labor Code section 4062.1(c) when the injured worker is not represented by an attorney, and when the injured worker is represented by an attorney, the physician whose name remains after completion of the striking process or who is otherwise selected as provided in Labor Code section 4062.2(c) when the parties are unable to agree on an Agreed Panel QME."

This definition was added for clarity to distinguish this type of QME from an Agreed Panel QME. Under Labor Code section 4062.2(b), when the injured employee is represented by an attorney, and the parties are unable to agree upon a physician to serve as an Agreed Medical Evaluator (AME), then a party must request a panel QME from the Medical Director. Once the Medical Director issues a panel list naming three qualified medical evaluators to select from, the represented parties are required by Labor Code section 4062.2(c) to attempt to agree on the name of one of the three physicians listed on the QME panel to serve as an agreed medical evaluator, now defined as an Agreed Panel QME. If the parties are unsuccessful in this process by the 10th day after the panel was issued, then each party is directed by Labor Code section 4062.2(c) to strike one physician name from the list, and the remaining QME will then serve as the panel QME in this represented

case. The term Panel QME also can mean the evaluator selected by an unrepresented injured employee pursuant to Labor Code section 4062.1(c). Finally, whenever an unrepresented injured employee fails to select a physician from the panel list as required by 4062.1(c), and whenever one of the parties in a represented case fails to strike an evaluator's name from the QME panel list as required by Labor Code section 4062.2(c), the other party is entitled to select an physician from the QME panel list to serve as the Panel QME. Accordingly, for clarity and to distinguish such panel-selected QMEs from the AME and Agreed Panel QME, this separate definition was necessary.

Other subdivisions of section 1 were re-lettered accordingly.

Prior § 1(x). "Primary Practice Location":
The proposed subdivision 1(x) "Primary Practice Location", proposed during the first 15 day comment period, was been deleted because the proposed regulatory language that used the term was also deleted from the regulations in its entirety.

Other subdivisions of section 1 were re-lettered accordingly.

§ 10. Appointment of QMEs

The following modifications were made in response to comments received.

Subdivision 10(b) was amended to delete proposed language that would have denied reappointment to a QME serving a period of probation imposed by the physician's licensing agency until the physician's license became unrestricted. A new sentence was added that provides: "Applications for appointment or reappointment from physicians who are on probationary license status with a California licensing board or agency while the QME application is pending shall be reviewed by the Medical Director on a case-by-case basis consistent with the provisions of Labor Code section 139.2(m). This additional language was added for clarity, to describe the review process, and to be consistent with Labor Code section 139.2(m) which provides, in pertinent part: "The administrative director shall suspend or terminate as a medical evaluator any physician who has been suspended or placed on probation by the relevant licensing board."

Subdivision 10(d) was amended to improve syntax and clarity to read: "Any physician who, while under investigation or after the service of a statement of issues or accusation for alleged violations of these regulations or the Labor Code, withdraws his or her application for appointment or reappointment, resigns or fails to seek reappointment as a QME, shall be subject to having the disciplinary process reactivated whenever an application for appointment or re-appointment is subsequently filed. In the event any of the alleged violations are found to have occurred, the physician's application for appointment or reappointment may be denied by the Administrative Director."

§ 11. Eligibility Requirements for Initial Appointment as a QME

The following modifications were made in response to comments received.

Subdivision 11(d) was amended to substitute the word “employee” with the word “worker” for consistency of terminology in the regulations.

Subdivision 11(e)(1) was amended to add the word “California” before the word “license”. This amendment was necessary for consistency with Labor Code section 139.2(b) and for clarity since physicians holding medical licenses from other states are allowed to perform other functions, as utilization reviewers, under the Labor Code. (See, Lab. Code section 4610.)

Subdivision 11(e)(4), as proposed during the first 15 day public comment period in this rulemaking and pertaining to spending 5 hours per week in direct medical treatment at each primary practice location has been deleted. The subdivision was deleted for consistency because the proposed subdivisions that defined and described the functions of a primary practice location were deleted in their entirety from this rulemaking, accordingly the proposed language in this subdivision was not needed. The subdivisions that followed have been, accordingly, re-numbered.

Subdivision 11(f)(8) was amended to change the word “two” to “five” in response to comments received on this topic during rulemaking. The Administrative Director decided to accept the comments that argued that a physician who is found to have cheated on the QME competency examination should be barred from retaking the exam for five years instead of two. Honesty and integrity by the physicians appointed as evaluators after passing the QME competency exam is the basis for all of the medical-legal reports written by such evaluators, signed under penalty of perjury and relied upon by the parties and the Workers’ Compensation Appeals Board in awarding benefits to injured workers. Accordingly, a greater penalty was deemed appropriate.

§ 11.5. Disability Evaluation Report Writing Course

The following modifications were made in response to comments received.

Subdivision 11.5(i)(3) was amended to add to the list of topics to be included in the curriculum of disability evaluation report writing courses, delete a reference to read:

“Factors of disability, including subjective and objective factors, loss of pre-injury capacity and work restrictions, for cases involving dates of injury not subject to the AMA guide-based impairment rating system

….

Activities of Daily Living, for cases subject to the AMA Guides

Work restrictions

….

Work Capabilities”

For consistency and clarity, the reference to ‘loss of pre-injury capacity’ was moved into a

conjunctive phrase with the term 'work restrictions', since these factors of disability must both be addressed in evaluations that determine permanent disability according to the Permanent Disability Rating Schedule in effect prior to January 1, 2005.

For consistency and clarity the topics of 'work restrictions' and 'work capabilities' were added since evaluation and reporting by an evaluator on these topics is essential to provide the injured worker and the claims administrator, or employer, with the information required by the parties to determine permanent disability under the Permanent Disability Rating Schedule adopted by the Administrative Director on 1/1/2005 and to determine appropriate job modifications, accommodations and related benefits.

And further down on the list:
"Vocational rehabilitation (for claims with dates of injury prior to January 1, 2004)" was amended for clarity and consistency to add the phrase in parenthesis, since this benefit is limited to claims with dates of injury prior to January 1, 2004. (See, Lab. Code §139.5.)

In addition, a new subdivision 11.5(i)(8) was added:

"(8) Submission and Critique of Written Medical/legal Report. As a condition of completion of the course taken to satisfy the requirements of this section, each physician enrollee shall draft at least one practice written medical/legal report, based on a sample case library of materials, which written report shall be critiqued with notations by the course education provider."

This requirement was added for clarity after the first fifteen day public comment period in response to comments from the public regarding the need to improvement the quality of QME continuing education regarding medical-legal evaluation reporting. The Administrative Director sought to make clear that the minimum standard for approving a course purporting to teach evaluators how to write medical-legal reports would require specific feedback in the form of notations by the course provider on a practice report written by the physician-enrollee. The cost to the parties in the system when they are required to obtain supplemental reports due to omissions or errors by the evaluator includes the cost of the supplemental report itself as well as potential litigation costs due to the delay in resolving the claim. The Administrative Director received no comments during the second fifteen day public comment period objecting to this clarifying language. It is the Administrative Director's view and conclusion that the approved educational course providers already provide this feedback to their enrollees who must pay for the course, and otherwise view the requirement as a reasonable standard to meet in the courses provided.

§ 12. Recognition of Specialty Boards

The following modifications were made in response to comments received.
In the Note following the section, the Labor Code sections listed for Authority were amended to add sections 139.4, 139.43 and 139.45 and the sections listed for Reference were amended to add Business and Professions Code section 651(i).

Business and Professions Code section 651(i) provides in pertinent part, "Each of the healing arts

boards *and examining committees* within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code." (emphasis added). This reference was added to comply with this statute, since in the view of the Administrative Director, it applies to the Board of Chiropractic Examiners, which is the "examining committee" in California with the exclusive jurisdiction to license and regulate doctors of chiropractic, who are "licensed…. *under any initiative act*" within the meaning of Business and Profession Code section 651(a).

§ 13. Physician's Specialty

The following modifications were made in response to comments received.
In the Note following the section, the Labor Code sections listed for Authority were amended to add sections 139.4, 139.43 and 139.45 and the sections listed for Reference were amended to add Business and Professions Code section 651(i).

These references to statutes were added in the Authority and Reference notes for this section for consistency and for the same reason stated directly above in reference to § 12.

§ 14. Doctors of Chiropractic: Certification in Workers' Compensation Evaluation

The following modifications were made in response to comments received.

Subdivision 14(b)(4)(E) was amended to improve syntax and clarity to read: "Continued and future medical care" as topics to be included in the final 36 hours of instruction in such courses. An injured worker may continue to require medical treatment after reaching maximum medical improvement, or becoming permanent and stationary. In addition, and distinct from that kind of continuing care which is known at the time of issuing a permanent disability award, the treating physician or a medical evaluator may find that given the injured employee's current condition, there will be a need for additional describable medical treatment in the future which can be identified and described with to a reasonable medical certainty. This benefit is called future medical treatment. Accordingly, both types of medical benefit must be addressed by chiropractic evaluators in medical-legal evaluation report to fully resolve an injury claim.

§ 17. Fee Schedule for QME

The following modifications were made in response to comments received.

Proposed subdivision 17(c), pertaining to certifying up to four primary practice locations, was deleted. The remaining subdivisions have been re-lettered accordingly.

The proposed wording in subdivision (d), that allowed the Administrative Director to waive any or all of the annual statutory fee for any or all QMEs whenever the Administrative Director determined that to be in the best interests of employers and injured employees has been deleted due to concerns

raised by control agencies about the fiscal impact to the state by this change.

Subdivision 17(e) was re-lettered to subdivision 17(d), due to the changes above.

§ 30. QME Panel Requests

The following modifications were made in response to comments received.

Subdivision 30(b) has been reworded for clarity to provide, among other things:

"(b) Represented cases. Requests for a QME panel in a represented case, for all cases with a date of injury on or after January 1, 2005, and for all other cases where represented parties agree to obtain a panel of Qualified Medical Evaluators pursuant to the process in Labor Code section 4062.2, shall be submitted on the form in section 106 (Request for a QME Panel under Labor Code Section 4062.2)(See, 8 Cal. Code Regs. § 106). The party requesting a QME panel shall: 1) identify the disputed issue that requires a comprehensive medical/legal report to be resolved; 2) attach a copy of the written proposal, naming one or more physicians to be an Agreed Medical Evaluator, that was sent to the opposing party once the dispute arose; 3) designate a specialty for the QME panel requested; 4) state the specialty preferred by the opposing party, if known; and 5) state the specialty of the treating physician. In represented cases with dates of injury prior to January 1, 2005, and only upon the parties' agreement to obtain a QME panel pursuant to Labor Code section 4062.2, the party requesting a QME panel shall submit QME Form 106 in compliance with this section and provide written evidence of the parties' agreement. Once such a panel in a represented case with a date of injury prior to January 1, 2005, is issued, the parties shall be bound by the timelines and process as described in Labor Code section 4062.2."

The phrase "naming one or more physicians to be an Agreed Medical Evaluator" and the phrase "…once the dispute arose…" were added for consistency to conform to the conditions set out in Labor Code § 4062.2(a) and 40602.2(b).

Subdivision 30(c) has been reworded for clarity and to improve punctuation, to provide:

" (~~b~~c) In the event a request form is incomplete, or improperly completed, so that a QME panel selection cannot properly be made, the request form shall be returned to the ~~employee~~ requesting party with an explanation of why the QME panel selection could not be made. The Medical Director also may delay issuing a new QME panel, if necessary, until **the Medical Director receives additional reasonable information requested from a party or both parties, needed to process the panel request. Reasonable information as used in this subdivision includes but is not limited to** whether a QME panel previously issued to the injured ~~employee~~ worker was used."

The last sentence of this subdivision 30(c) that appeared in the prior version of the proposed regulation text, regarding the tolling of time frames, has been moved and re-worded as a new proposed subdivision 30(h), for clarity.

Subdivision 30(d) was reworded, for clarity, consistency and to improve syntax, to provide:

"(d)(1) After a claim form has been filed, the claims administrator, or if none the employer**,** may request a panel of Qualified Medical Evaluators only as provided in Labor Code section 4060, to determine whether to accept or reject a claim within the ninety (90) day period for rejecting liability in Labor Code section 5402(b), and only after providing evidence of compliance with Labor Code Section 4062.1 or 4062.2.

(d)(2) Once the claims administrator, or if none~~,~~ the employer, has accepted as compensable injury to any body part in the claim, a request for a panel QME may only be filed based on a dispute arising under Labor Code section 4061 or 4062.

(d)(3) Whenever an injury or illness claim of an employee has been denied entirely by the claims administrator**,** or if none by the employer, only the employee may request a panel of Qualified Medical Evaluators, as provided in Labor Code sections 4060(d) and 4062.1 if unrepresented***,*** or as provided in Labor Code sections 4060(c) and 4062.2 if represented.

(d)(4) After the ninety (90) day period specified in Labor Code section 5402(b) for denying liability has expired, a request from the claims administrator, or if none from the employer, for a QME panel to determine compensability shall only be issued upon presentation of a finding and decision issued by a Workers' Compensation Administrative Law Judge that the presumption in section 5402(b) has been rebutted and an order that a QME panel should be issued to determine compensability . The order shall also specify the residential or, if applicable, the employment-based zip code from which to select evaluators and either the medical specialty of the panel or which party may select the medical specialty."

The wording change is made for clarity and to comply with current workers' compensation law. Labor Code sections 4060(c), which applies to claims in which the injured employee is represented by an attorney, and 4060(d), which applies to claims in which the injured employee is unrepresented, each provide: "If a medical evaluation is required *to determine compensability*…" (emphasis added.) (See, Lab. Code § § 4060(c) and 4060(d).) Further, Labor Code section 4060(a) provides, in pertinent part, "This *section* shall not apply where injury to any part or parts of the body is accepted as compensable by the employer." Therefore, once any body part in a workers' compensation *claim* is accepted by the employer as *compensable,* the *claim* is accepted as compensable within the meaning of Labor Code section 4062(a), and there no longer is a need for the claims administrator, or employer, to obtain an evaluation *to determine compensability.*

Moreover, in the event a new body part is added to the claim after it has been accepted as compensable, or newly discovered evidence is received that was not available prior to the time the claim was accepted or became presumptively compensable under Labor Code section 5402(b), the claims administrator or employer is able to object to and challenge the *medical determination* made by the primary treating physician, or other employee physician, that the new body part is a compensable industrial injury or illness. Labor Code section 4062(a) provides, in pertinent part:

> "(a) If the employee or employer objects to a *medical determination* made by the treating physician concerning any medical issues *not covered by Section 4060 or 4061 and not*

subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney." (emphasis added)

As the Legislature provided in section 4062(a), an employer's, or claims administrator's, objection to a claimed new body part, or to a previously accepted body part once newly discovered evidence is received, is "not covered by Labor Code section 4060" because, pursuant to Labor Code section 4060(a) above, the entire section does not apply once a claim has been accepted. Similarly, Labor Code section 4061 does not apply because it addresses only disputes pertaining to disability not whether injury to a new body part was causally related to the existing accepted claim. Finally, Labor Code section 4610, which governs utilization review of medical treatment requests, does not cover such objections because section 4610, and its implementing regulations in sections 9792.6 *et seq.* of Title 8 of the California Code of Regulations, apply only to physicians' determinations of *medical necessity,* and does not cover or include determinations of causation or work-relatedness. (See, Lab. Code sections 4610(a) and (e), 8 Cal. Code Regs. Sections 9792.6(s), 9792.9(f), 9792.9(j)(6); See also, State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Sandhagen) *(2008)* 44 Cal. 4th 230, 186 P. 3d 535; 79 Cal.Rptr. 171; 73 Cal.Comp.Cases 981 (hereafter, *Sandhagen).*

In addition, the phrase "residential or, if applicable, the employment-based zip code from which to select evaluators and either the" is a necessary addition in the last sentence of the subdivision, to ensure that a Workers' Compensation Administrative Law Judge's order that a QME panel be issued can be fulfilled by the Medical Unit without delay, by specifying either the employee's residential zip code or workplace zip code, as required. (See, Lab. Code § 139.2(h)(4); 8 Cal. Code Regs. § 31.5(a)(3) and 31.5(b)(2)).

Subdivision 30(e) was amended for clarity to provide:

"(e) If the request form is submitted by or on behalf of an employee who no longer resides within the state of California, the geographic area of the QME panel selection within the state shall be determined by agreement between the claims administrator, or if none the employer, and the employee. If no agreement can be reached, the geographic area of the QME panel selection shall be determined for an unrepresented employee by the employee's former residence within the state, and for a represented employee by the office of the employee's attorney."

Subdivision 30(f), which proposed during the first 15 day comment period, to give 1.5 times the weight to primary practice locations was deleted for consistency since all wording referring to primary practice locations was deleted in response to comments. The following subdivisions were re-lettered accordingly.

A new subdivision 30(g) was added:

"(g) The panel request in a represented case must be sent to the Medical Unit address on the QME Form 106 by means of first class mail delivered by the United States postal service. The Medical

Unit will not accept panel requests in represented cases that are delivered in person by a party, the party's attorney, any other person or by other commercial courier or delivery services."

The phrase "first class mail" is used for clarity and to conform to other regulations addressing how parties in represented cases may deliver their requests for a QME panel under Labor Code section 4062.2, since the first valid request received must be filled. (See, Lab. Code § 4062.2(b).) Due to the 'race' created by the provisions of Labor Code section 4062.2, as enacted by SB 899, the Administrative Director has determined it is necessary for fairness and to comply with this section, to require both parties to use the same method of delivery for panel requests.

After the second 15 day public comment period the phrase ", any other person…" was inserted after "party's attorney", for clarity and to avoid confusion caused by ambiguity that a friend or volunteer of a party or their attorney might be allowed to deliver the panel request to the Medical Unit.

A new subdivision 30(h), which previously was the last sentence of subdivision 30(c), was added:

> "(h) The time periods specified in Labor Code sections 4062.1(c) and 4062.2(c), respectively, for selecting an evaluator from a QME panel and for scheduling an appointment, shall be tolled whenever the Medical Director asks a party for additional information needed to process the panel request. These time periods shall remain tolled until the date the Medical Director issues either a new QME panel or a decision on the panel request."

In response to a comment received during the second 15 day comment period, and for clarity, the Administrative Director substituted the word "resolve" with the word "process".

§ 31. QME Panel Selection

The following modifications were made in response to comments received.

Subdivision 31(b), pertaining to making appointments with a panel QME and not discussing the selection of a QME with an unrepresented injured worker, was deleted from this section for clarity and is now addressed in a new proposed section 31.3, discussed below. The remaining subdivisions of section 31 were re-lettered accordingly.

Subdivision 31(c) has been reworded for clarity and consistency with existing law and other regulations being adopted in this rulemaking to provide:

"(~~d~~ c) Any physician who has served as a primary treating physician or secondary physician and who has provided treatment to the employee in accordance with section ~~9785.5~~ 9785 ~~this~~ Title 8 of the California Code of Regulations for ~~this~~ the disputed injury ~~for an unrepresented employee~~ shall not perform a QME evaluation on that employee. Whenever that ~~QME~~ physician's name appears on a QME panel, he or she shall disqualify him or herself if contacted by a party to perform

the evaluation. ~~the employee~~ Either party may request a replacement QME for this reason pursuant to section 31.5 of Title 8 of the California Code of Regulations.

§31.1 QME Panel Selection Disputes in Represented Cases

The following modifications were made in response to comments received.

Subdivision 31.1(c) has been amended for clarity to add the following sentence: "Any such order shall specify the specialty of the QME panel or the party to be designated to select the specialty."

This information is need in the order to enable the Medical Unit to process the panel request.

§31.3. Scheduling Appointment with Panel QME

In response to comments received, a new section 31.3 is proposed which provides:

"§31.3. Scheduling Appointment with Panel QME

(a) When the employee is not represented by an attorney, the unrepresented employee shall, within ten (10) days of having been furnished with the form, select a QME from the panel list, contact the QME to schedule an appointment and inform the claims administrator of the QME selection and the appointment .

(b) Neither the employer, nor the claims administrator nor any other representative of the employer shall discuss the selection of the QME with an unrepresented worker who has the legal right to select the QME.

(c) If, within ten (10) days of the issuance of a QME panel, the unrepresented employee fails to select a QME from the QME panel or fails to schedule an appointment with the selected QME, the claims administrator may schedule an appointment with a panel QME only as provided in Labor Code section 4062.1(c), and shall notify the employee of the appointment as provided in that section.

(d) Whenever the employee is represented by an attorney and the parties have completed the conferring and striking processes described in Labor Code section 4062.2(c), the represented employee shall schedule the appointment with the physician selected from the QME panel. If the represented employee fails to do so within ten (10) business days of the date a QME is selected from the panel, the claims administrator or administrator's attorney may arrange the appointment and notify the employee and employee's attorney.

Note: Authority: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 4060, 4061, 4062,4062.1, 4062.2, 4064 and 4067, Labor Code"

This section expands on the provisions of subdivision 30(b) of Title 8 of the California Code of Regulations and Labor Code section 4062.1 and 4062.2 regarding panel issuance and QME

selection. To improve clarity and consistency with existing law, the Administrative Director determined a new section was necessary. The language added, that refers to the ten day time period is consistent, with the ten day time limit specified in Labor Code section 4062.1(b), which requires the unrepresented injured worker to select a medical specialty for the QME and submit the form to the Medical Director so that a panel may be issued.

Subdivision (c) allows a claims administrator to select a QME and schedule an appointment if the unrepresented injured worker fails to do so within 10 days of issuance of the panel.

§ 31.5. QME Replacement Requests

The following modifications were made in response to comments received.

Subdivision 31.5(a) was amended to read:

"(2) A QME on the panel issued cannot schedule an examination for the employee within sixty (60) days of the initial request for an appointment, or if the 60 day scheduling limit has been waived pursuant to section 33(e) of Title 8 of the California Code of Regulations, the QME cannot schedule the examination within ninety (90) days of the date of the initial request for an appointment.

This additional language was added in conformance with Labor Code section 139.2(j)(1)(C), which directs the Administrative Director to adopt regulations governing the availability of QMEs within a specified time frame, but, in pertinent part: "These time frames shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, *but shall also permit the employee to waive this right for a specified period of time thereafter*."

Subdivision 31.5(a) was also amended to read:

"(3) The injured worker has changed his or her residence address since the QME panel was issued and prior to date of the initial evaluation of the injured worker."

The new phrase was added for necessity and consistency with the provision in Labor Code section 4062.3(j) that once an evaluation has been prepared, the parties to the extent possible shall utilize the same medical evaluator.

Subdivision 31.5(a) was also amended for clarity to read:

"(6) The evaluator who previously reported in the case is no longer available."

Subdivision 31.5(a) was also amended for clarity to read:

"(7) A QME named on the panel is currently, or has been, the employee's primary treating physician or secondary physician as described in section 9785 of Title 8 of the California Code of

Regulations for the injury currently in dispute ."

Subdivision 31.5(a) was also amended for clarity and necessity to read:

"(8) The claims administrator, or if none the employer, and the employee agree in writing, for the employee's convenience only, that a new panel may be issued in the geographic area of the employee's work place and a copy of the employee's agreement is submitted with the panel replacement request."

It is necessary for the Medical Director to receive some evidence of the employee's agreement that for his or her convenience the employee agreed to request a QME panel in the general geographic location of his or her workplace. Receiving this with the panel request will avoid delays while the Medical Director contacts the employee to verify his or her agreement.

Subdivision 31.5(a) was also amended for clarity and necessity to read:

(10) The Medical Director, upon written request, filed with a copy of the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021 [see 8 Cal. Code Regs. §§ 14006 and 14007) and the most recent DWC Form PR-2 ("Primary Treating Physician's Progress Report" [See 8 Cal. Code Regs. § 9785.2) or narrative report filed in lieu of the PR-2 , determines after a review of all appropriate records that the specialty chosen by the party holding the legal right to designate a specialty is medically or otherwise inappropriate for the disputed medical issue(s). The Medical Director may request either party to provide additional information or records necessary for the determination."

This amendment was necessary to address cases in which the disputed medical issue may go beyond the scope of practice of the treating and evaluating physician. For example, an injured worker with an industrial hand injury may be treated by a doctor of chiropractic and the panel QME selected may be a doctor of chiropractic. However, after extended conservative care without improvement, a disputed issue of the need for surgery may arise and the panel QME licensed as a doctor of chiropractic would not be qualified to address the need for surgery as surgery is outside of that QME's scope of practice.

Subdivision 31.5(a) was also amended for clarity, to improve syntax, consistency and necessity to read:

(11) The evaluator has violated section 34 (Appointment Notification and Cancellation) of Title 8 of the California Code of Regulations, except that the evaluator will not be replaced for this reason whenever the request for a replacement by a party is made more than fifteen (15) calendar days from either the date the party became aware of the violation of section 34 of Title 8 of the California Code of Regulations or the date the report was served by the evaluator, whichever is earlier.

The Administrative Director determined that placing a time limit on using this reason to obtain a new medical-legal evaluation was necessary because some parties would wait until trial before

raising this technical objection, months after the evaluation report was issued, rated and the basis for attempted settlements. Such a late technical objection creates additional delays and costs to the opposing party and the Workers' Compensation Appeals Board, and thwarts the statutory scheme that attempts to enable the parties to settle benefits claims fairly and expeditiously. This change preserves the rights of the parties to object on the basis of a QMEs violation of the appointment notification and cancellation regulation but not surprise the opponent long after that technical breach is still relevant.

Subdivision 31.5(a) was also amended for clarity and to improve syntax, to read:

"(12) The evaluator failed to meet the deadlines specified in Labor Code section 4062.5 and section 38 (Medical Evaluation Time Frames) of Title 8 of the California Code of Regulations and the party requesting the replacement objected to the report on the grounds of lateness prior to the date the evaluator served the report. A party requesting a replacement on this ground shall attach to the request for a replacement a copy of the party's objection to the untimely report."

Subdivision 31.5(a) was also amended for clarity and to improve syntax, to read:

"(14) The Administrative Director has issued an order pursuant to section 10164(c) of Title 8 of the California Code of Regulations (order for additional QME evaluation)."

Subdivision 31.5(a) was also amended for clarity, to improve syntax and for consistency, to read:

"(15) The selected medical evaluator, who otherwise appears to be qualified and competent to address all disputed medical issues refuses to provide, when requested by a party or by the Medical Director, either: A) a complete medical evaluation as provided in Labor Code sections 4062.3(i) and 4062.3(j), or B) a written statement that explains why the evaluator believes he or she is not medically qualified or medically competent to address one or more issues in dispute in the case."

Other regulations in this rulemaking allow parties to obtain a replacement QME or an additional QME panel in another specialty when the existing evaluator fails to provide a complete report, as required by Labor Code section 4062.3(i) and 4062.3(j), or verbally tells a party that the evaluator believes he or she is not medically qualified or medically competent to address a disputed issue. Because the physician evaluator is most qualified to make that determination based on the scope of his or her license and medical training and clinical experience, a written statement from the evaluator, rather than from a party relying on a verbal conversation with the evaluator, is the supporting documentation the Medical Unit needs to replace the evaluator on this ground. This written communication from the evaluator is necessary to avoid replacing the evaluator, therefore denying his or her opportunity to report in the case, based on a misunderstanding by the party who might request replacement for this purpose. It will minimize mistakes and avoid objections from the opposing party or an evaluator who does not believe he or she is medically qualified and competent to report in the case.

Subdivision 31.5(a) was also amended for clarity, to improve syntax and for consistency, to read:

"(16) The QME panel list was issued more than twenty four (24) months prior to the date the

request for a replacement is received by the Medical Unit, and none of the QMEs on the panel list have examined the injured worker."

This provision is necessary to avoid delays in processing an otherwise valid panel request. Too often when a panel request is received by the Medical Unit, the Medical Unit has a record of a panel already issued to the injured employee in the case for the same injury but no indication whether the injured employee or the claims administrator used the earlier panel. Because the workers' compensation reform bills AB 749 (2002), SB 228 (2004) and SB 899 (2004) each changed the medical-legal evaluation system to limit the number of medical-legal evaluations performed for the same claimed injury, the Medical Unit must verify whether a previously issued panel ever was used. This creates delays for the parties. From experience of the Medical Unit in this regard, the Administrative Director is satisfied that in the event a previously issued QME panel was not used, that is no QME on the panel list already examined the injured worker, it is more expeditious to simply void the earlier stale panel and issue a new panel to the parties. Since QMEs are appointed for two year terms, the 24 month time frame is consistent with the QME's expectation of opportunity to be selected from a panel and reimbursed for performing an evaluation.

Further, the wording for subdivision 31.5(b), proposed during the first 15 day comment period and pertaining to conditions under which a party would qualify to obtain an additional QME panel in a different medical specialty, was moved to a new section 31.7, discussed below. The remaining subdivisions of 31.5 accordingly were re-lettered, to become 31.5(b) and 31.5(c) as stated above.

Subdivisions 31.5(b) and (c) were amended for clarity and consistency with statutes and other regulations governing the time periods for selecting QMEs or the striking process in represented cases:

"(b) Whenever the Medical Director determines that a request made pursuant to subdivision 31.5(a) for a QME replacement or QME panel replacement is valid, the time limit for an unrepresented employee to select a QME and schedule an appointment under section Labor Code section 4062.1(c) and the time limit for a represented employee to strike a QME name from the QME panel under Labor Code section 4062.2(c), shall be tolled until the date the replacement QME <u>name</u> or QME panel is issued."

(c) In the event the parties in a represented case have struck two QME names from a panel and subsequently a valid ground under subdivision 31.5 arises to replace the remaining QME, none of the QMEs whose names appeared on the earlier QME panel shall be included in the replacement QME panel."

Subdivision 31.5(d), proposed during the first 15 day comment period and pertaining to an order from a Workers' Compensation Administrative Law Judge to act on requests for replacements due to the evaluator's failure to timely serve the report, has been deleted for consistency. Labor Code section 4062.5, as amended by SB 899, does not require a Workers' Compensation Administrative Law Judge (WCALJ) order to issue a replacement QME. Unless both parties agree to waive the lateness and accept the late filed report, by the express wording of the statute, a new QME or QME panel must be issued by the Medical Unit.

§ 31.7. Obtaining Additional QME Panel in a Different Specialty

In response to comments received, the wording previously proposed during the first 15 day comment period as subdivision 31.5(b), was moved for clarity to this new section and additional wording was added, such that the proposed new section provides:

"§ 31.7. Obtaining Additional QME Panel in a Different Specialty

(a) Once an Agreed Medical Evaluator, an Agreed Panel QME, or a panel Qualified Medical Evaluator has issued a comprehensive medical/legal report in a case and a new medical dispute arises, the parties, to the extent possible, shall obtain a follow-up evaluation or a supplemental evaluation from the same evaluator.

(b) Upon a showing of good cause that a panel of QME physicians in a different specialty is needed to assist the parties reach an expeditious and just resolution of disputed medical issues in the case, the Medical Director shall issue an additional panel of QME physicians selected at random in the specialty requested. For the purpose of this section, good cause means:

(1) An order by a Workers' Compensation Administrative Law Judge for a panel of QME physicians that also either designates a party to select the specialty or states the specialty to be selected and the residential or employment-based zip code from which to randomly select evaluators; or

(2) The AME or QME selected advises the parties and the Medical Director, or his or her designee, that she or he has completed or will complete a timely evaluation of the disputed medical issues within his or her scope of practice and areas of clinical competence but recommends that a new evaluator in another specialty is needed to evaluate one or more remaining disputed medical conditions, injuries or issues that are outside of the evaluator's areas of clinical competence, and either the injured worker is unrepresented or the parties in a represented case have been unable to select an Agreed Medical Evaluator for that purpose; or

(3) A written agreement by the parties in a represented case that there is a need for an additional comprehensive medical legal report by an evaluator in a different specialty, that attempts to select an Agreed Medical Evaluator pursuant to Labor Code section 4062.2 for that purpose have failed and the specialty that the parties have agreed upon for the additional evaluation; or

(4) In an unrepresented case, that the parties have conferred with an Information and Assistance Officer, have explained the need for an additional QME evaluator in another specialty to address disputed issues and, as noted by the Information and Assistance Officer on the panel request form, the parties have reached agreement in the presence of and with the assistance of the Officer on the specialty requested for the additional QME panel. The parties may confer with the Information and Assistance Officer in person or by conference call.

Note: Authority cited: Sections 133, 139.2, 4061, 4062, 4062.3, 4062.5, 5307.3 and 5703.5, Labor Code. Reference: Sections 139.2, 4062, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

In subdivision 31.7(b)(1), the words: “and the residential or employment-based zip code from which to randomly select evaluators” are necessary to ensure that the orders issued by a Workers’ Compensation Administrative Law Judge (WCALJ) for a QME panel provide the information the Medical Director needs to do a random search consistent with Labor Code section 139.2.

In subdivision 31.7(a)(4), the words “and with the assistance of” before the words Information and Assistance Officer, were added for clarity. The intent is to allow the injured employee and the claims administrator to ask questions and obtain answers about their options while reaching agreement on a QME panel specialty.

§ 32. Consultations

The following modifications were made in response to comments received.

Subdivision 32(a) has been amended to delete the phrase “party holding the legal right to select the specialty” and to replace it with the words “QME acupuncturist”. This change is needed to clarify that, in a case in which the QME selected is an acupuncturist, who is unable to address disability issues as provided by Labor Code 3209.3(e), and therefore needs a consulting report from a physician as defined in Labor Code section 3209.3 that may address disability issues, it is the QME acupuncturist who must select the consulting physician, not a party. This change is consistent with the remainder of wording in the section which allows only the evaluating QME to select a consulting physician when needed.

Subdivision 32(b) has been amended to capitalize the word “Guides”.

Subdivision 32(c) has been re-added to the section without the reference to a prior treating physician and, as amended, reads:

“(c) For injuries occurring on or after January 1, 1994, a QME may obtain a consultation from any physician as reasonable and necessary pursuant to Labor Code section 4064(a).”

Labor Code section 4064(a) provides that “the employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061 and 4062. Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms.” The Administrative Director has determined that the wording as currently proposed in 32(c) would allow a QME to obtain a consultation from any physician as reasonable and necessary pursuant to Labor Code section 4064(a) and in view of the first sentence that requires an employer to pay for each reasonable and necessary evaluation, there is no need for the stricken phrase “or upon the agreement by a party to pay the cost.” Other provisions in Labor Code sections 4061 and 4062, as enacted by SB 899, expressly limit the number of admissible reports a party may obtain. (See, Lab. Code §§ 4061(i) and last sentence of 4062 (a).)

Subdivision 32(d) is newly added wording that specifies that the referring QME evaluator, who

determines a consultation is necessary, must select the physician to serve as the consulting, not the parties. The section clarifies that the referring QME must arrange the appointment with the consulting physician and advise the parties of the time, date and place on QME Form 110.

The Administrative Director determined this wording was necessary to remove ambiguity about the responsibilities of the referring QME who decides a consultation is necessary. With the exception of using QME form 110, this is the process existing QMEs follow when arranging a consultation with another physician who may not be a QME. Use of the form is a simple, readily available, familiar form and method for the referring QME to notify the injured worker and the claims administrator of the time, place and date of the consultation examination.

Subdivision 32(e) is newly added wording that specifies that the consulting physician must serve his or her report on the referring QME, and the referring QME must review the consulting report, incorporate it by reference into a medical-legal report by the referring QME, and comment on the consulting physicians findings and conclusions in the referring QME's report.
The Administrative Director determined this wording was necessary to remove ambiguity about the responsibilities of the referring QME. This practice would be required by Labor Code sections 4062.3(d), 4628 and WCAB rule 10606 (of Title 8 of the California Code of Regulations) as currently is the practice of QMEs who obtain consultations. It is necessary to remove any ambiguity regarding these procedures.

Subdivision 32(f) is newly added wording that specifies that the referring evaluator who refers to a consulting physician must still file his or her medical-legal report timely, and if the consulting physician's report is not yet available, to file a supplemental medical-legal report once the consulting physician's report is received. This is necessary to clarify and be consistent with other statutes and regulations governing the time in which a medical-legal report must be filed.

After the second 15 day comment period, the following sentence was added for clarity and consistency with the requirements in Labor Code 4062.3(d): "The referring evaluator shall list, in the report commenting on the consulting physician's report, all reports and information received from each party for the consulting physician, indicate whether each item was forwarded to the consulting physician, and for the items not forwarded the reason the referring evaluator determined it was necessary to forward the item to the consulting physician." This language clarifies that, as required under Labor Code section 4062.3(d), the referring evaluator must identify all reports reviewed and relied upon, and otherwise ensures each party is able to challenge the evaluation report if a medical record or history relevant to the disputed injury has been considered.

Subdivision 32(g) is newly added wording that specifies that the parties must communicate with the consulting physician only through the referring QME first. This is subdivision is necessary to remove ambiguity about communications with a consulting physician and to be consistent with the limitations on ex parte communication in Labor Code section 4062.3 and Title 8, Cal. Code Regs., section 35.

These new subdivisions are necessary to remove ambiguity for the regulated evaluators and the parties (injured employee and claims administrator or employer) whenever a consulting physician

assists in the resolution of a disputed claim.

§ 32.6 Additional QME Evaluations Ordered by the Appeals Board

Subdivision 32.6 was amended to read (in underline): "The Medical Director shall issue a panel of Qualified Medical Evaluators upon receipt of an order of a Workers' Compensation Administrative Law Judge or the Appeals Board, that includes a finding that an additional evaluation is reasonable and necessary to resolve disputed issues under Labor Code sections 4060, 4061 or 4062. The order shall specify the residential or employment-based zip code from which to randomly select evaluators, specify the specialty for the QME panel or designate the party who shall select the specialty of the QME panel, and specify who shall select a new specialty in the event there are too few QMEs in the specialty initially selected to issue a panel in accordance with section 31(d) of Title 8 of the California Code of Regulations."

This information is needed by the Medical Director to comply with the Workers' Compensation Administrative Law Judge's order consistent with the provisions in Labor Code section 139.2 for random panel selection in the geographic vicinity of the injured employee's residence or consistent with existing regulation that allows the injured employee to request a panel in the vicinity of the workplace (See, 8 Cal. Code Regs. § 31.5(b)).

The Labor Code section references to "5703 and 5703.5" are added for consistency in citing authority.

§ 32.7 Availability of QME for Panel Assignment

In response to comments received in the first 15 day comment period, this entire newly proposed section is being deleted.

§ 33. Unavailability of QME

The following modifications were made in response to comments received.

Subdivision 33(a) has minor wording changes for clarity, improved syntax and consistency.

Subdivision 33(c) deletes the reference to "or AME" after "as a QME", such that the subdivision as proposed now provides:

"(c) A QME who is unavailable as provided in subdivision (a) shall not perform any new evaluation examinations as a QME until the physician returns to active QME status. Such a QME may complete medical-legal examinations and reports already scheduled and reported to the Medical Director, as well as reports for evaluation examinations performed prior to becoming unavailable under subdivision (a). Such a QME also may complete supplemental reports."

Subdivision 33(e) has been amended to add the word "sixty" before "(60)" for consistency, and to add the wording shown below by underline, to provide:

"(e) If a party with the legal right to schedule an appointment with a QME is unable to obtain an appointment with a selected QME within 60 days of the date of the appointment request, that party may waive the right to a replacement in order to accept an appointment no more than ninety (90) days after the date of the party's initial appointment request. When the selected QME is unable to schedule the evaluation within ninety (90) days of the date of that party's initial appointment request, either party may report the unavailability of the QME and the Medical Director shall issue a replacement pursuant to section 31.5 of Title 8 of the California Code of Regulations upon request, unless both parties agree in writing to waive the ninety (90) day time limit for scheduling the initial evaluation."

By this wording, the Administrative Director revised the existing wording in subdivision 33(c), for consistency by referring to the party with the right to schedule the appointment throughout. Also, for consistency with subdivision 31.5(a)(2), as now proposed, and Labor Code section 139.2(j)(1)(C), quoted above in the discussion of changes to 8 Cal. Code Regs. § 31.5(a)(2), the added wording allows either party to report unavailability if either party declines to waive the 90 day time limit.

Subdivision 33(f) has been amended, to improve clarity and syntax, to provide:

"(f) If a QME fails to notify the Medical Director, by submitting the form in section 109 (Notice of Qualified Medical Evaluator Unavailability) (see, 8 Cal. Code Regs. § 109), of his or her unavailability at a medical office at least thirty (30) days prior to the period the evaluator becomes unavailable, the Medical Director may designate the QME to be unavailable at that location for thirty (30) days from the date the Medical Director learns of the unavailability."

Subdivision 33(g) has been amended to reduce the time for a QME to respond to a certified letter from the Medical Director, regarding the QME's unavailability and failure to respond to calls or mail at a given location, from 30 days to 15 days. As proposed, the QME would be made unavailable at that location for failing to respond within 15 days of the date of the certified letter. No comments in opposition to this provision were received during the second 15 day public comment period. In the experience of the Medical Unit, evaluators who are active and available and receive a certified letter from the Medical Unit respond very quickly so the additional 15 day delay for the parties was found to be unnecessary.

§ 34. Appointment Notification and Cancellation

The following modifications were made in response to comments received.

The title of this section was amended to add the words "and Cancellation" for clarity since added subdivisions address procedures pertaining to cancelling a scheduled evaluation.

Subdivision 34(a) was amended for clarity and to improve syntax and cross reference, to read as follows:

"(a) Whenever an appointment for a comprehensive medical evaluation is made with a QME, the QME shall complete an appointment notification form by submitting the form in Section 110 (QME Appointment Notification Form)(See, 8 Cal. Code Regs. § 110). The completed form shall be postmarked or sent by facsimile to the employee and the claims administrator**,** or**,** if none**,** the employer**,** within 5 business days of the date the appointment was made. In a represented case, a copy of the completed form shall also be sent to the attorney who represents each party, if known. Failure to comply with this requirement shall constitute grounds for denial of reappointment under section 51 of Title 8 of the California Code of Regulations."

A new subdivision 34(d) was added:

"(d) An evaluator, whether an AME, Agreed Panel QME or QME, shall not cancel a scheduled appointment less than six (6) business days prior to the appointment date, except for good cause. Whenever an evaluator cancels a scheduled appointment, the evaluator shall advise the parties in writing of the reason for the cancellation. The Appeals Board shall retain jurisdiction to resolve disputes among the parties regarding whether an appointment cancellation pursuant to this subdivision was for good cause. The Administrative Director shall retain jurisdiction to take appropriate disciplinary action against any Agreed Panel QME or QME for violations of this section."

Necessity: The proposed requirement limits the evaluator and the parties when making cancellations or rescheduling appointments to a minimum notice period of six or more days before the scheduled examination. This change is made in response to two kinds of complaints received by the Medical Director: 1) complaints from injured workers who do not receive adequate notice that the evaluator has cancelled the appointment and learn of the cancellation only upon arriving at the scheduled time and location; and 2) complaints by QMEs about claims administrators calling in appointment cancellations without adequately explaining the reason the appointment is being cancelled or without sufficient notice to enable the QME to schedule a different patient into the cancelled appointment time. By requiring the evaluator or party who timely cancels a scheduled appointment to provide a written explanation, the instances of cancelling without good cause will be discouraged.

Subdivisions 34(e), (f) and (g) were added to read:

> "(e) An Agreed Panel QME or a QME who cancels a scheduled appointment shall reschedule the appointment to a date within thirty (30) calendar days of the date of cancellation. The re-scheduled appointment date may not be more than sixty (60) calendar days from the date of the initial request for an appointment, unless the parties agree in writing to accept the date beyond the sixty (60) day limit.

Subdivision 34(e) is necessary for consistency with the availability limitations in Labor Code section 139.2(j)(1)(C) and subdivision 31.5 (a)(2) of the proposed regulations in Title 8, that require a QME to be available to schedule an appointment within 60 days of the call for appointment, unless the scheduling party agrees to accept an appointment 90 days from the initial call.

Subdivision 34(f) was added for necessity to address complaints received by the Medical Director from both represented applicants and defendants about unreasonable delays in obtaining appointments and examinations with Agreed Medical Evaluators.

> "(f) An Agreed Medical Evaluator who cancels a scheduled appointment shall reschedule the appointment within sixty (60) calendar days of the date of the cancellation."

While some commenters argued the time limits for AMEs should be the same as those for QMEs, the Administrative Director determined that such a limitation would be unworkable as many AMEs have calendars that are booked further in advance than QMEs generally have.

In response to comments received during the second 15 day comment period on this subdivision, the Administrative Director amended it to:

> "(f) An Agreed Medical Evaluator who cancels a scheduled appointment shall reschedule the appointment within sixty (60) calendar days of the date of the cancellation unless the parties agree in writing to accept an appointment date no more than thirty (30) calendar days beyond the sixty (60) day limit."

Further, the Administrative Director is concerned, based on comments and complaints from parties, that the parties' have experienced unending delays in obtaining reports from AMEs. The AME who cancels a scheduled appointment has an obligation to the parties' who have had to accept the initial cancellation, even in cancellations due to good cause.

Subdivision 34(g) was amended for clarity and consistency with Labor Code section 4062.3 and 8 Cal. Code Regs. § 38, which addresses extensions of time for completion of a medical-legal report:

> "(g) Failure to receive relevant medical records, as provided in section 35 of Title 8 of the California Code of Regulations and section 4062.3 of the Labor Code, prior to a scheduled appointment shall not constitute good cause under this section for the evaluator to cancel the appointment."

In response to comments from psychiatrists and psychologists during the second 15 day comment period, the Administrative Director amended subdivision 34(g) to add after "appointment" in the existing sentence: "…unless the evaluator is a psychiatrist or psychologist performing an evaluation regarding a disputed injury to the psyche who states in the evaluation report that receipt of relevant medical records prior to the evaluation was necessary to conduct a full and fair evaluation."

In the Administrative Director's view, the commenters raised an important medical issue that goes to the core of the medical evaluation process that a psychiatrist or psychologist is required to make in conducting some but not all evaluations in a disputed claim to the psyche. To assess the injured worker's veracity based on a correct or conflicting account of the injury, prior psychological episodes and their impact, it is more important to have the relevant medical records in advance in order to assess whether the discrepancies are due to being a poor historian or some other cause. For

this reason, the Administrative Director concluded the added language is a necessary clarification given the medical opinion involved in the underlying this wording change.

Subdivision 34(h) has been reworded to provide:

> "(h) An appointment scheduled with an evaluator, whether an AME, Agreed Panel QME or QME shall not be cancelled or rescheduled by a party or the party's attorney less than six (6) business days before the appointment date, except for good cause. Whenever the claims administrator, or if none the employer, or the injured worker, or either party's attorney, cancels an appointment scheduled by an evaluator, the cancellation shall be made in writing, state the reason for the cancellation and be served on the opposing party. Oral cancellations shall be followed with a written confirming letter that is faxed or mailed by first class U.S. mail within twenty four hours of the verbal cancellation and that complies with this section. An injured worker shall not be liable for any missed appointment fee whenever an appointment is cancelled for good cause. The Appeals Board shall retain jurisdiction to resolve disputes regarding whether an appointment cancellation by a party pursuant to this subdivision was for good cause."

Subdivision 34(i) has been added for clarity to provide:

> "(i) The date of cancellation shall be determined from the date of postmark, if mailed, or from the facsimile receipt date as shown on the recipient's fax copy."

The text proposed in each of the subdivisions in section 34 above is necessary to clarify for the evaluators and for the parties the conditions under which the evaluator may cancel an appointment (34(d)), the evaluator must reschedule a cancelled appointment (34(e)), the time limit within which an Agreed Medical Evaluator must reschedule a cancelled appointment (34(f)), that non-receipt of medical records does not provide a reason for canceling appointments (34(g)), the conditions under which the party may cancel appointments (34(h)), and how the date of cancellation shall be determined (34(i)).

§ 35. Exchange of Information and Ex Parte communications

The following modifications were made in response to comments received.

Subdivision 35 was amended (as shown in underline) to state:

"(a) Except as provided in subdivision 35(m) below, the claims administrator, or~~,~~ if none~~,~~ the employer, shall provide, and the injured worker may provide, the following information to the evaluator , whether an AME, Agreed panel QME or QME:"

After the second 15 day comment period, the Administrative Director amended subdivision 35(a), for clarity and consistency, to delete the phrase "Except as provided in subdivision 35(m) below,".

Subdivision 35(m), as proposed after the first 15 day comment period, would have extended the provisions of regulation 35, regarding exchange of information and ex parte communications, to consulting physicians. The Administrative Director, instead, determined it would be more consistent with the existing practice regulated by subdivision 32 of Title 8 of the California Code of Regulations, to instead have the parties communicate through the selected QME rather than directly with the consulting physician. Consulting physicians may provide an evaluator with essential specialized medical knowledge on a consulting basis, but often are not certified QMEs and are unfamiliar with the requirements of the rules governing QMEs and the workers' compensation system. Accordingly, the Administrative Director deleted the proposed subdivision 35(m), added clarifying language on the issue of communications for the consulting physician in subdivision 32, and therefore is now deleting this reference to subdivision 35(m) in the introductory clause of 35(a).

Subdivision 35(a)(2), (3), (4) and (5) were amended for clarity and to improve syntax, to provide:

"(2) Other medical records, including any previous treatment records or information, which are relevant to determination of the medical issue(s) in dispute;

(3) A letter outlining the issues that the evaluator is requested to address in the evaluation, which shall be served on the opposing party no less than 20 days in advance of the evaluation ;

(4) Whenever the treating physician's recommended medical treatment is disputed, a copy of the treating physician's report recommending the medical treatment with all supporting documents, a copy of claims administrator's, or if none the employer's, decision to approve, delay, deny or modify the disputed treatment with the documents supporting the decision, and all other relevant communications about the disputed treatment exchanged during the utilization review process required by Labor Code section 4610;

(5) Non-medical records, including films and videotapes, which are relevant to determination of medical issue(s) in dispute, after compliance with subdivision 35(c) of Title 8 of the California Code of Regulations.

The term "evaluator" is necessary for consistency, in place of "AME or QME" to be consistent with the definition of evaluator in subdivision 1(s) of Title 8 of the California Code of Regulations.

Subdivision 35(b) was amended for clarity to provide:

"(b)(1) All communications by the parties with the evaluator shall be in writing and sent simultaneously to the opposing party when sent to the medical evaluator, except as otherwise provided in subdivisions (c), (k) and (l) of this section.'

The term "evaluator" is necessary for consistency, in place of "AME or QME" in subdivision 35(b)(1), to be consistent with the definition of evaluator in subdivision 1(s) of Title 8 of the California Code of Regulations. The reference to subdivision 35(l) was added for consistency because in represented cases with dates of injury prior to 1/1/2005, each represented party is entitled to communicate privately with their own evaluator.

Subdivision 35(b)(2) was amended for clarity to provide:

"(2) Represented parties who have selected an Agreed Medical Evaluator or an Agreed Panel QME shall, as part of their agreement, agree on what information is to be provided to the AME or the Agreed Panel QME, respectively."

Here, for consistency with the specialized rules that apply to represented cases using AMEs or Agreed Panel QMEs, the term evaluator cannot be used, so instead the specific identifiers are used for clarity.

Subdivision 35(c) was amended to provide:

"(c) At least twenty (20) days before the information is to be provided to the evaluator, the party providing such medical and non-medical reports and information shall serve it on the opposing party. In both unrepresented and represented cases the claims administrator shall attach a log to the front of the records and information being sent to the opposing party that identifies each record or other information to be sent to the evaluator and lists each item in the order it is attached to or appears on the log. In a represented case, the injured worker's attorney shall do the same for any records or other information to be sent to the evaluator directly from the attorney's office, if any. The claims administrator, or if none the employer, shall include a cover letter or other document when providing such information to the employee which shall clearly and conspicuously include the following language: "Please look carefully at the enclosed information. It may be used by the doctor who is evaluating your medical condition as it relates to your workers' compensation claim. If you do not want the doctor to see this information, you must let me know within 10 days."

The term "evaluator" is necessary for consistency, in place of "AME or QME" to be consistent with the definition of evaluator in subdivision 1(s) of Title 8 of the California Code of Regulations.

The sentence requiring the claims administrator to attach a log of records furnished is necessary to enable the evaluator and the parties to determine they have received all records being sent. In an unrepresented case, the claims administrator must furnish copies of these records to the evaluator. Many claims administrators currently do so with a log as that specified in this wording. In addition, the same requirement was added to the attorneys in represented cases. No comments in opposition to this proposal were received after the first 15 day comment period.

The phrase "or if none the" before "employer" is added for consistency.

After the second 15 day comment period, in response to comments received and for consistency with Health and Safety Code section 123115(b), the following sentence was added to subdivision 35 (c) as a new second sentence, followed by the remainder of the subdivision as quoted above:

"Mental health records that are subject to the protections of Health and Safety Code section 123115(b) shall not be served directly on the injured employee, but may be provided to a designated health care provider as provided in section 123115(b)(2), and the injured employee shall be notified in writing of this option for each such record to be provided to the evaluator."

The Administrative Director determined this added sentence is necessary since Health and Safety Code section 123112(b) specifically prohibits a physician from providing a mental health record subject to a determination made under that section to the patient or person about whom the mental health record pertains. This added language makes clear for the regulated parties the procedure to be followed in such an instance for such a record.

Subdivision 35(d) was amended for clarity and to improve syntax, to provide:

"(d) If the opposing party objects within 10 days to any non-medical records or information proposed to be sent to an evaluator, those records and that information shall not be provided to the evaluator unless so ordered by a Workers' Compensation Administrative Law Judge."

Subdivision 35(e) was amended for clarity and to improve syntax, to provide:

"(e) In no event shall any party forward to the evaluator: (1) any medical/legal report which has been rejected by a party as untimely pursuant to Labor Code section 4062.5; (2) any evaluation or consulting report written by any physician other than a treating physician, the primary treating physician or secondary physician, or an evaluator through the medical-legal process in Labor Code sections 4060 through 4062, that addresses permanent impairment, permanent disability or apportionment under California workers' compensation laws, unless that physician's report has first been ruled admissible by a Workers' Compensation Administrative Law Judge; or (3) any medical report or record or other information or thing which has been stricken, or found inadequate or inadmissible by a Workers' Compensation Administrative Law Judge, or which otherwise has been deemed inadmissible to the evaluator as a matter of law."

The language in subdivision 35(e) that limits the parties to sending the evaluator only reports written by treating physicians, primary treating physicians or secondary physicians, or evaluators pursuant through the medical-legal process under Labor Code sections 4060 through 4062, that addresses permanent impairment, permanent disability or apportionment under California's workers' compensation laws, unless that physician's reports otherwise has been ruled admissible by a Workers' Compensation Administrative Law Judge, is necessary due to a tactic used by some parties to circumvent the provisions of Labor Code 4062.3 and regulation 35 on the exchange of information. The tactic involves obtaining an expert consultant's report about permanent disability which is then sent to the treating physician or the evaluator by the claims administrator in the case as one of many "treating physician" records. Since the evaluator, pursuant to Labor Code section 40602.3(d) and section 35 of the regulations, is required to identify and comment on all medical records received, these reports, which otherwise would be inadmissible, become part of the medical record as though they are treatment reports, when in actuality they are inadmissible expert evaluator reports obtained outside of the provisions of the Labor Code. Labor Code § 4061(i), as enacted by SB 899, expressly addresses this kind of tactic and provides:

"With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations resulting from the injury shall be obtained, except in accordance with Section 4062.1 and 4062.2. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board."

Accordingly, the Administrative Director determined the added language in subdivision 35(e) is necessary to clarify that only the reports of treating physicians and medical-legal evaluators obtained through the process in Labor Code sections 4060 through 4062, may be sent to an evaluator until the proponent of the report obtains a ruling from a Workers' Compensation Administrative Law Judge that such a report is admissible.

Subdivision 35(g) was amended for clarity, consistency and cross-reference, to provide:

"(g) Copies of all records being sent to the evaluator shall be sent to all parties except as otherwise provided in section (d) and (e). Failure to do so shall constitute ex parte communication within the meaning of subdivision (k) below by the party transmitting the information to the evaluator. "

Subdivision 35(i), 35(j) and 35(k) were amended, to replace the word "QME" with the word "evaluator" for consistency with the definition in subdivision 1(s) of "evaluator", to provide:

" (i) In the event that a party fails to provide to the evaluator any relevant medical record which the evaluator deems necessary to perform a comprehensive medical-legal evaluation, the evaluator may contact the treating physician or other health care provider, to obtain such record(s). If the party fails to provide relevant medical records within 10 days after the date of the evaluation, and the evaluator is unable to obtain the records, the evaluator shall complete and serve the report to comply with the statutory time frames under section 38 of Title 8 of the California Code of Regulations. The evaluator shall note in the report that the records were not received within the required time period. Upon request by a party, or the Appeals Board, the evaluator shall complete a supplemental evaluation when the relevant medical records are received. For a supplemental report the evaluator need not conduct an additional physical examination of the employee if the evaluator believes a review of the additional records is sufficient.

(j) The evaluator and the employee's treating physician(s) may consult as necessary to produce a complete and accurate report. The evaluator shall note within the report new or additional information received from the treating physician.

(k) The Appeals Board shall retain jurisdiction in all cases to determine disputes arising from objections and whether ex parte contact in violation of Labor Code section 4062.3 or this section of Title 8 of the California Code of Regulations has occurred. If any party communicates with an evaluator in violation of Labor Code section 4062.3, the Medical Director shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator. Oral or written communications by the employee, or if the employee is deceased by the employee's dependent, made in the course of the examination or made at the request of the evaluator in connection with the examination shall not provide grounds for a new evaluator unless the Appeals Board has made a specific finding of an impermissible ex parte communication."

Subdivision 35(l) was amended after the first 15 day comment period to delete the proposed language, which described the procedure an evaluator would use to advise the parties of an issue outside of the scope of the evaluator's license or areas of clinical competence, and to move that

language to a new section, now addressed in subdivisions 31.7, 35.5(d) and 32.6 of Title 8 in this proposed rulemaking.

However, the Administrative Director determined it was necessary to add the language quoted below, for clarity and to be consistent with current case law, that recognizes that notwithstanding the amendments made by SB 899 to Labor Code sections 4062.1 and 4062.2, in represented cases involving dates of injury prior to January 1, 2005, each represented party is entitled to obtain a separate medical-legal evaluator to provide an opinion on disputed benefits issues in the case. (See, *Nunez v. Workers' Comp. Appeals Bd.* (2006) 136 Cal. App. 4th 584, 38 Cal. Rptr. 3d 914, 71 Cal. Comp. Cas. 161; *Cortez v. Workers' Comp. Appeals Bd.* (2006) 136 Cal. App. 4th 596, 38 Cal. Rptr. 3d 922, 71 Cal. Comp. Cas. 155):

> "(l) In claims involving a date of injury prior to 1/1/2005 where the injured worker is represented by an attorney and the parties have decided to each select a separate Qualified Medical Evaluator, the provisions of this section shall not apply to the communications between a party and the QME selected by that party."

§ 35.5. Compliance by AMEs and QMEs with ~~IMC~~ Administrative Director Evaluation and Reporting Guidelines

The following modifications were made in response to comments received.

Subdivision 35.5(c) was amended for clarity and to improve syntax, and to add the sentence: "The reporting evaluator shall attempt to address each question raised by each party in the issue cover letter sent to the evaluator as required by subdivision 35(a)(3)."

A new subdivision 35.5(d) was added, which provides:

> "(d) At the evaluator's earliest opportunity and no later than the date the report is served, the evaluator shall advise the parties in writing of any disputed medical issues outside of the evaluator's scope of practice and area of clinical competency in order that the parties may initiate the process for obtaining an additional evaluation pursuant to section 4062.1 or 4062.2 of the Labor Code and these regulations in another specialty. In the case of an Agreed Panel QME or a panel QME, the evaluator shall send a copy of the written notification provided to the parties to the Medical Director at the same time. However, only a party's request for an additional panel, with the evaluator's written notice under this section attached, or an order by a Workers' Compensation Administrative Law Judge, will be acted upon by the Medical Director to issue a new QME panel in another specialty in the claim."

This subdivision is necessary to specify the steps an evaluator must take to advise the parties in writing when the evaluator determines that there are disputed issues beyond the scope of practice or clinical competence of the evaluator, in order that the parties may obtain an additional QME panel to address those disputed issues.

Subdivision 35.5(d), as proposed after the first 15 day public comment period, was re-lettered as subdivision 35.5(e):

> "(e) In the event a new injury or illness is claimed involving the same type of body part or body system and the parties are the same, or in the event either party objects to any new medical issue within the evaluator's scope of practice and clinical competence, the parties shall utilize to the extent possible the same QME or AME who reported previously."

This subdivision is necessary to be consistent with the provisions of Labor Code section 4062.3(i) and 4062.3(j). The wording addresses an ambiguity in Labor Code section 4062.3(i) that refers to "prior to the date of the employee's *initial* appointment with the medical evaluator." By this wording in subdivision 35.5(e), when the body part or body system is the same in the claim and the disputed medical issue is within the evaluator's scope of practice and clinical competence, the same evaluator would be used to address the issue, even though that issue became disputed after the date of the initial medical-legal examination the injured worker had with that evaluator. This scenario often occurs when an injured worker has a specific date of injury, for which an initial evaluation is performed, and subsequently amends the claim to allege a cumulative trauma injury to the same body part.

After the second 15 day comment period, the Administrative Director substituted the word "evaluator" for the words "QME or AME". This was a non-substantive change made for consistency in subdivision 35.5(e).

Subdivision 35.5(e) was re-lettered as a new 35.5(f), and was amended for clarity in response to public comments referring to Labor Code section 5710 pertaining to depositions, to provide:

> "(f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall, upon the request of either party, make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and whenever consistent with Labor Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed."

This proposed wording was found necessary to clarify the parties' options, to expressly provide that the parties, whether represented or not, could agree to another location for the deposition, and when no agreement for an alternate location was made, that upon request of either party, the deposition would be held at the location where the evaluation was performed whenever that location was consistent with Labor Code section 5710.

Labor Code section 5710 provides, in pertinent part, that any party to a proceeding before the Workers' Compensation Appeals Board, "…cause the deposition of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil actions in the superior courts of this state under Title 4 (commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure." The deposition rules in the Code of Civil Procedure referred to in Labor Code section 5710, however, apply only upon the appeals board gaining jurisdiction of the

case. The appeals board has no jurisdiction prior to the date a party files an application for adjudication with the appeals board. (See, Lab. Code § 5500.)

Pursuant to the Administrative Director's jurisdiction under Labor Code sections 133, 139.2 and 5307.3, to regulate the QME procedures prior to the time the appeals board gains jurisdiction, the Administrative Director proposed the initial regulatory language in subdivision 35.5(e), regarding depositions of evaluators. The Administrative Director issued the proposed regulation requiring an evaluator made him or herself available with a specified maximum period of time (120 days), due to complaints from parties that some evaluator's continually rescheduled depositions, which created a delay and interfered with discovery in disputed workers' compensation cases. In addition, the Administrative Director was concerned, especially in the case of an unrepresented injured worker, that if the worker wished to attend the deposition scheduled by the claims administrator or defense attorney, that the location of the deposition be reasonably close to the location of the evaluation, which must be within the general geographic area of the injured worker's residence or workplace. (Lab. Code § 139.2(h)(3)(b); 8 Cal. Code Regs. § 31.5(a)(2).)

However, in order to provide a regulation governing depositions of evaluators that could provide conditions that are consistent both with the jurisdiction of the Administrative Director, and Labor Code section 5710 in the event the deposition was noticed after the WCAB jurisdiction attached, modified wording was needed.

Code of Civil Procedure section 2025.250, provides in regard to the distance for compelling a deponent to attend a deposition, in pertinent part:

> "(a) Unless the court orders otherwise under Section 2025.260, the deposition of a natural person, whether or not a party to the action, shall be taken at a place that is, *at the option of the party giving notice of the deposition*, either within 75 miles of the deponent's residence or within the county where the action is pending and within 150 miles of the deponent's residence."

Accordingly, in an effort to harmonize the jurisdiction of the Administrative Director over the procedures to which QME evaluators must adhere, with the jurisdiction of the appeals board to issue subpoenas and the provisions of Labor Code section 5710 and Code of Civil Procedure section 2025.250, the proposed wording of subdivision 35.5(f), as quoted above, was necessary to provide the regulated QMEs and the parties guidance, and it was circulated for a second 15 day comment period.

After the second 15 day comment period, and in response to comments received at that time, the wording was further amended by the Administrative Director for clarity, to provide:

> (f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and, <u>upon the</u>

request of the unrepresented injured worker and whenever consistent with Labor Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed, or at a facility or office chosen by the deposing party that is not more than 20 miles from the location of the evaluation examination."

The phrase "upon the request of either party" was replaced by "upon the request of the unrepresented injured worker" for clarity. This provision is necessary since the unrepresented injured worker, unlike a claims administrator, defense attorney or applicant's attorney, is not compensated for his or her travel time or deposition time while attending a deposition scheduled by the opposing party, especially if it is scheduled at a location far from the worker's residence or workplace. The phrase '…or at a facility or office chosen by the deposing party that is not more than 20 miles from the location of the evaluation examination," was necessary to harmonize these statutes and competing policy considerations, for three reasons: 1) to address the circumstance when the evaluator's examination office does not have suitable space for a deposition; 2) to address the circumstance when the evaluator prefers not disrupt the practice at that office by accommodating a deposition at that location; and 3) in recognition of the civil discovery procedural statutes that allow the deposing party to select an appropriate location.

Subdivision 35.5(g), initially proposed as subdivision 35.5(d), was re-lettered and amended to read:

"(g) Whenever an Agreed Medical Evaluator or Qualified Medical Evaluator provides an opinion in a comprehensive medical/legal report on a disputed medical treatment issue, the evaluator's opinion shall be consistent with and apply the standards of evidence-based medicine set out in Division 1, Chapter 4.5, Subchapter 1, sections 9792.20 et seq of Title 8 of the California Code of Regulations (Medical Treatment Utilization Schedule). In the event the disputed medical treatment, condition or injury is not addressed by the Medical Treatment Utilization Schedule, the evaluator's medical opinion shall be consistent with and refer to other evidence-based medical treatment guidelines, peer reviewed studies and articles, if any, and otherwise shall explain the medical basis for the evaluator's reasoning and conclusions."

These phrases were added for clarity and consistency. Labor Code section 4600 provides, in pertinent part, that the employer provide "medical treatment that is reasonably required to cure or relieve…", which is defined as "…treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27…" (See, Lab. Code § 4600(b).) Labor Code section 4604.5(a) provides in pertinent part that the guidelines adopted pursuant to section 5307.27 are "…presumptively correct on the issue of extent and scope of medical treatment." Further, Labor Code section 4610, which governs utilization review, and its implementing regulations found at 8 Cal. Code Regs. §§ 9792.6 – 9792.15, require that physicians who review requests for authorization of medical treatment for medical necessity must explain, whenever denying, delaying or modifying the original requested treatment: 1) the reasons for the decision; 2) the medical criteria or guidelines used in the medical necessity review; and 3) the clinical reasons for the medical necessity determination. (See, 8 Cal. Code Regs. § 9792.9(j).) Accordingly, the Administrative Director determined this proposed language was necessary in order to direct evaluators to draft their opinions on necessary current, continuing or future medical treatment in a

manner that could be judged along with the other medical evidence in the case from the treating physician and any reviewing physician during utilization review.

§ 36. ~~Summary Form for Comprehensive Medical-Legal Evaluation Performed Pursuant to Labor Code Section 4061 by QMEs or AMEs; Service of Form and Evaluation~~ Service of Comprehensive Medical-Legal Evaluation Reports by Medical Evaluators Including Reports Under Labor Code section 4061

The following modifications were made in response to comments received. The section title has been changed for clarity.

Subdivisions 36 (a), (b) and (c) have been deleted and re-worded and replaced as follows, for clarity:

> "(a) Whenever an injured worker is represented by an attorney, the evaluator shall serve each comprehensive medical-legal evaluation report, follow-up comprehensive medical-legal evaluation report and supplemental evaluation report on the injured worker, his or her attorney and on the claims administrator, or if none the employer, by completing QME Form 122 (AME or QME Declaration of Service of Medical-Legal Report Form)(See, 8 Cal. Code Regs.§ 122) and attaching QME Form 122 to the report, unless section 36.5 of Title 8 of the California Code of Regulations applies. If applicable in a claim involving disputed injury to the psyche, the evaluator shall comply with the requirements of section 36.5 of Title 8 of the California Code of Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs.§§ 36.5, 120 and 121).
>
> (b) Whenever an injured worker is not represented by an attorney, the Qualified Medical Evaluator shall serve each comprehensive medical-legal evaluation report, follow-up evaluation report or supplemental report that addresses only disputed issues outside of the scope Labor Code section 4061, by completing the questions and declaration of service on the QME Form 111 (QME Findings Summary Form) (See, 8 Cal. Code Regs. § 111), and by serving the report with the QME Form 111 attached, on the injured worker and the claims administrator, or if none on the employer, unless section 36.5 of Title 8 of the California Code of Regulations applies. If applicable in a claim involving disputed injury to the psyche, the evaluator shall comply with the requirements of section 36.5 of Title 8 of the California Code of Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs.§§ 36.5, 120 and 121.)
>
> (c) Whenever the evaluator is serving a medical-legal evaluation report that addresses or describes findings and conclusions pertaining to permanent impairment, permanent disability or apportionment of an unrepresented injured worker, the evaluator shall serve the evaluation report, the completed QME Form 111 (QME Findings Summary Form) (See, 8 Cal. Code Regs. § 111), DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) and DWC-AD form 101 (DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's

Report)(See, 8 Cal. Code Regs. §§10160 and 10161) on the local DEU office, the claims administrator, or if none the employer, and on the unrepresented employee within the time frames specified in section 38 of Title 8 of the California Code or Regulations, unless section 36.5 of Title 8 of the California Code of Regulations applies. If applicable, in cases involving disputed injury to the psyche, the evaluator shall follow the procedures described in section 36.5 of Title 8 of the California Code of Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs.§§ 36.5, 120 and 121)."

After the second 15 day public comment period, the phrase "…with the document cover sheet, DWC-CA form 10232.1 (see, 8 Cal. Code Regs. § 10232.1), and separator sheet, DWC-CA form 10232.2 (see, 8 Cal. Code Regs. § 10232.2), as required by Title 8, California Code of Regulations section 10160(d)(4),…." was inserted in subdivision 36(c) for clarity, consistency and cross-reference. These references specify the newly adopted forms any person must use when filing a document at a DEU office, pursuant to 8 Cal. Code Regs. §§ 10160 and 10232 *et seq*. As the note section below subdivision 36 states, the forms referred to in this phrase are available to evaluators and to the public at no charge on the Division's website.

Minor wording changes also were made in subdivision 36(d) and 36(e), to improve syntax and clarity and without changing the meaning or obligations under those subdivisions.

Subdivision 36(e) was amended, as follows:

"(~~d~~ ***e***) ~~A~~ ***After a*** Qualified Medical Evaluator ~~who~~ has served a comprehensive medical-legal report on an unrepresented injured worker, the claims administrator, or if none the employer, and the Disability Evaluation Unit, that addresses a disputed issue involving permanent impairment, permanent disability or apportionment, ***the QME*** shall not issue any supplemental report on that issue, unless requested to do so by the Disability Evaluation Unit, by the Administrative Director in response to a petition for reconsideration of a disability rating or by a Workers' Compensation Administrative Law Judge."

Many comments were received during the second 15 day comment period regarding subdivision 36(e).

All of the comments on subdivision 36(e) received during the second 15 day comment period address issues that are well-beyond the text changes presented for public comment in that period, and therefore are rejected on that basis alone.

However, upon further reflection as a result of the comments, and to improve the clarity and consistency of the proposed subdivision 36(e), in light of the general statutory and regulatory scheme pertaining to medical-legal reports that find and discuss permanent disability and apportionment in the case of an unrepresented injured worker, the Administrative Director further amended the subdivision as follows, after the second 15 day comment period:

"(~~d~~ e) After a Qualified Medical Evaluator ~~who~~ has served a comprehensive medical-legal report that finds and describes permanent impairment, permanent disability or apportionment in the case of an unrepresented injured worker, ~~the claims administrator, or if none the employer, and the Disability Evaluation Unit, that addresses a disputed issue~~

~~involving permanent impairment, permanent disability or apportionment,~~ the QME shall not issue any supplemental report on ~~that~~ any of those issues in response to a party's request until after the Disability Evaluation Unit has issued an initial summary rating report, or unless the evaluator is otherwise directed to issue a supplemental report by the Disability Evaluation Unit, by the Administrative Director ~~in response to a petition for reconsideration of a disability rating~~ or by a Workers' Compensation Administrative Law Judge. A party wishing to request a supplemental report pursuant to subdivision 10160(f) of Title 8 of the California Code of Regulations, based on the party's objection to or need for clarification of the evaluator's discussion of permanent impairment, permanent disability or apportionment, may do so only by sending the detailed request, within the time limits of subdivision 10160(f), directly to the DEU office where the report was served by the evaluator and not to the evaluator until after the initial summary rating has been issued."

This amended wording is necessary to be consistent with the other existing statutes and regulations that govern the procedures to be followed once the QME in an unrepresented injured worker case issues a medical-legal report that finds and describes permanent disability or apportionment. It is also necessary to be consistent with the statutory safeguards enacted by the Legislature in regard to the unequal knowledge basis between an unrepresented injured worker and a claims administrator or defense attorney, in regard to the complex medical-legal issues relating to permanent impairment, permanent disability, rating permanent disability and apportionment.

Labor Code sections 4061 provides in pertinent part:

"(e) The qualified medical evaluator who has evaluated *an unrepresented employee* shall serve the comprehensive medical evaluation and the summary form on the employee, employer, and the administrative director. The unrepresented employee or the employer may submit the treating physician's evaluation for the calculation of a permanent disability rating. *Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate* the permanent disability rating according to Section 4660 and serve the rating on the employee and employer.

(f) Any comprehensive medical evaluation concerning *an unrepresented employee* which indicates that part or all of an employee's permanent impairment or limitations *may be subject to apportionment* pursuant to Sections 4663 and 4664 shall first be submitted by the administrative director to a workers' compensation judge who may refer the report back to the qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

(g) *Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating* or obtain additional information from the treating physician or *medical evaluator* to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative director shall

return the report to the treating physician or qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer." (emphasis added)

From these sections, as enacted by SB 899, it is clear that in the case of an unrepresented injured worker whose medical-legal evaluation report finds and discusses permanent impairment, permanent disability or apportionment, the evaluator must serve the report on the parties and the administrative director. Within 20 days, a permanent disability rating must be calculated and served on the injured worker and the employer (or the employer's claims administrator). The calculation is done by disability rating specialists in the Disability Evaluation Unit (DEU). (See, 8 Cal. Code Regs. §§ 10160 *et seq*.) When the report addresses apportionment, the discussion on apportionment must be reviewed by a Workers' Compensation Administrative Law Judge to determine whether the evaluator's opinion on apportionment in the report is consistent with existing law. (Lab. Code § 4061(f); 8 Cal. Code Regs. § 10163.) A party who receives the evaluator's report, served pursuant to Labor Code § 4061(e), who objects to the opinions on permanent disability and apportionment in the report must raise the objection and request a supplemental report within 20 days of receipt of the report. (See, 8 Cal. Code Regs. § 10160(f); Lab. Code § 4061(g).) Once the summary rating is issued by the DEU and served on the parties, a party who wishes to object to the rating has several options: 1) ask for any supplemental report to be rated; 2) petition the Administrative Director to reconsider the rating or to obtain additional information from the evaluator (Lab. Code § 4061(g); 8 Cal. Code Regs. § 10164); 3) file an application at the appeals board and depose the evaluator; 4) file a motion or request a hearing at the appeals board to ask that the report be stricken as failing to constitute substantial evidence or request a hearing to cross-examine the rating specialist about the rating.

Each of these subdivision of Labor Code section 4061(e), (f) and (g) prescribes specific procedures in an unrepresented worker's case to obtain a determination, from the Division (through DEU as a rating or the Administrative Director as a rating reconsideration) or from a Workers' Compensation Administrative Law Judge (WCALJ), in regard to the permanent disability rating and the adequacy of the evaluator's opinion on permanent impairment, disability and apportionment. Each of these offices of the Division provide disinterested, experienced personnel knowledgeable in the applicable law and procedures pertaining to permanent disability and apportionment.

The Administrative Director receives complaints from experienced WCALJ's about claims administrators requesting repeated, serial supplemental reports from evaluators that often advocate a particular interpretation of this complex area of law in the letter to the evaluator. The WCALJ's expressed great concern that the unrepresented injured worker generally lacks sufficient technical knowledge of permanent disability and apportionment rules and law to know whether to object to the contents of the supplemental report request letter sent to the evaluator before the evaluator responds. In their experience, most unrepresented injured workers do not seek to discuss these issues, and the contents of any such claims administrator letters to the QME, until after an initial summary permanent disability rating has issued.

Accordingly, the Administrative Director finds that subdivision 36(e), as currently proposed, is necessary to comport with the statutory scheme discussed above, to address the unequal knowledge base between an unrepresented injured worker and the defense representatives responding to the injured worker's claim for permanent disability benefits, and to provide the parties with a disinterested, knowledgeable summary rating prior to the evaluator's receipt of correspondence from a party questioning or challenging the evaluator's medical opinion about permanent impairment, permanent disability or apportionment. Subdivision 36(e), as currently proposed, would still enable an aggrieved party to request a supplemental report from the evaluator once the initial summary rating has been issued. The rating is used to determine the percentage, and therefore the monetary value, of permanent disability benefits. Accordingly, a procedure that supports a fair rating determination process in an unrepresented case prior to the parties engaging in any settlement discussions based on the rating in the case is necessary to accomplish the goals of the California workers' compensation system.

§ 36.5 Service of Comprehensive Medical/Legal Report in Claims of Injury to the Psyche

In response to comments received, this new section is proposed to address service of a medical/legal report in cases involving a disputed injury to the psyche. The section, as now proposed, gives the AME or QME two options for serving the report on the injured worker.

In cases in which the evaluator makes a determination as provided under Health and Safety Code section 123115(b), that the evaluation report or other medical records reviewed by the evaluator should not be seen directly by the injured worker due to a substantial risk of significant adverse or detrimental medical consequences, the evaluator is directed to serve the report only on a physician designated by the injured worker who will be paid for one office visit to discuss the report without allowing the injured worker to review it personally. The physician need not be the primary treating physician in the workers' compensation claim since the employer often "controls medical treatment" by either selecting or controlling the pool of physicians available to the injured worker as a primary treating physician. The claims administrator, or if none the employer, is required to pay for such an office visit. A new proposed QME Form 121 is being proposed for the evaluator to use when he or she makes such a determination.

As previously proposed in subdivision 36(c) during the initial 45 day public comment period, whenever the evaluator does not make the specific determination required by Health and Safety Code section 123115(b), but is concerned the injured worker may misinterpret part or all of the comprehensive medical/legal report, the evaluator may ask the injured worker if he or she wishes to use a method of voluntary alternate service in which the worker will designate a physician to whom the report will be served and who will be paid for one office visit to review the report with the injured worker prior to giving the worker his or her copy. The physician need not be the primary treating physician in the workers' compensation claim. The wording of proposed QME Form 120 has been amended to reflect this process.

Subdivision 36.5(a) was been added to this section during the second 15 day comment period, and the remaining subdivisions re-lettered, and it provides:

> "(a) At the beginning of any evaluation involving a claimed or disputed injury to the psyche, the injured worker shall be advised by the evaluator that the comprehensive medical-legal report, and any follow up or supplemental reports, from the evaluation may be served either directly on the injured worker or instead on a physician designated in writing by the injured worker prior to leaving the evaluator's office, for the purpose of reviewing and discussing the evaluation report with the injured worker. The evaluator shall explain that the designated physician need not be the injured worker's primary treating physician in the workers' compensation claim and that the employer will pay for one office visit with the designated physician for this purpose."

This subdivision is necessary to clarify the procedures for evaluators to use when performing a medical-legal evaluation involving a disputed injury to the psyche, in order that the injured worker will be informed by the evaluator about the options for service of the employee's copy of the evaluation report.

After the second 15 day comment period the wording in subdivision 36.5(a) was edited in response to comments, as follows for clarity and to improve syntax, without changing the meaning or obligations of the subdivision as previously proposed (changes shown by underlining):

> "(a) <u>For</u> any evaluation involving a claimed or disputed injury to the psyche, the injured worker shall be advised by the evaluator <u>that the employee's copy of</u> the comprehensive medical-legal report, and any follow up or supplemental reports, from the evaluation may be served either directly on the injured worker or instead on a physician designated in writing by the injured worker prior to leaving the evaluator's office, for the purpose of reviewing and discussing the evaluation report with the injured worker. The evaluator shall explain that the designated physician <u>may be but</u> need not be the injured worker's primary treating physician in the workers' compensation claim and that the employer <u>will be responsible for payment</u> for one office visit with the designated physician for this purpose.:

Subdivision 36.5(b) requires an evaluator who makes a determination under Health and Safety Code section 123115(b) to: 1) complete the declaration on proposed QME Form 121; 2) advise the injured worker that such a determination has been made and that the employee's copy of the report itself may only be served on a licensed physician, as defined by Labor Code section 3209.3, or on the injured worker's attorney, if any; 3) permit inspection and copying of the designated mental health record by a licensed physician or health care provider; 4) attach a copy of the completed QME Form 121 to the medical/legal report or other medical record; and 5) only serve the completed medical/legal report with the Form 121 attached on the physician designated by the injured worker, on the claims administrator, on the DEU when the report addresses permanent impairment or permanent disability, and on the party's attorneys, if any.

Subdivision 36.5(c) defines ‘mental health record’ for the purposes of this subdivision.

Subdivisions 36.5(d), (e), (f), (g), (h), (i) and (j) have been amended for clarity, to improve syntax and to correct cross reference.

Subdivision 36.5(d) provides that service in compliance with this section shall be deemed to satisfy the evaluator’s obligation to serve the employee’s copy of the report under Labor Code sections 139.2(j)(1) and 4061(c) and under section 36 of Title 8 of the California Code of Regulations.

Subdivision 36.5(e) requires the claims administrator and all parties and their attorneys to keep mental health records subject to a determination under Health and Safety Code section 123115(b) and this subdivision confidential, and when filing such a report at the Workers’ Compensation Appeals Board to request and obtain a protective order from a Workers’ Compensation Administrative Law Judge that specifies the manner in which the record may be inspected, copied and entered into evidence.

Subdivision 36.5(f) provides that when injury to the psyche is in dispute and the evaluator does not make a determination under Health and Safety Code section 123115(b) as described in 36.5(a) above, but is concerned the injured worker may misinterpret part or all of the report, the evaluator may ask the injured worker whether the individual wishes to voluntarily direct that an alternate method of service of the report be used, by completing QME Form 120 prior to the end of the evaluation visit.

Subdivision 36.5(g) provides that upon receipt of a QME Form 120 completed by the injured worker, the evaluator shall serve the report on the physician designated by the employee. Service by the evaluator in compliance with this subdivision shall be deemed to satisfy the evaluator’s obligation to serve the employee’s copy of the report under Labor Code sections 139.2(j)(1) and 4061(c) and under section 36 of Title 8 of the California Code of Regulations.

Subdivision 36.5(h) provides that as an additional medical expense incurred in the claim, the claims administrator, or if none the employer, shall reimburse the physician designated by the injured worker on QME Form 120 or 121, for one office visit, when used for the purpose of reviewing and discussing the evaluator’s report with the injured worker, at the OMFS rate for an office visit and may include, as appropriate, record review, any necessary, face-to-face time during the visit in excess of that specified in the CPT office visit code and charges, if necessary, for time required to prepare a treatment report.

Subdivision 36.5(i) provides that when the injured worker directs alternate service on QME Form 120 that the evaluator serve two copies of the report, one of which will be provided to the injured employee during the visit with the physician designated on the form.

Subdivision 36.5(j) provides that whenever the comprehensive medical-legal report is served by the evaluator on a physician pursuant to subdivision 36.5(f) with the QME Form 120 attached, one

of the two copies of the medical-legal report served on the designated physician shall be given to the injured worker by the designated physician during the office visit.

Subdivision (k) provides that in the event the injured worker declines or refuses to designate any physician in writing to be listed on either QME Form 120 or QME Form 121, the evaluator's report shall be served as appropriate under section 36, and within the time periods under section 38, of Title 8 of the California Code of Regulations. It is recommended that the evaluator serve the medical-legal evaluation report with an authorization for release of medical information signed by the injured worker. A non-mandatory Authorization for Release of Medical Information form is available as QME Form 125.

Necessity: In addition to the request from several commenter's to address the issue of a Health and Safety Code 123115(b) determination and how it would apply as an alternate form of service of a medical/legal report in a disputed injury to the psyche claim, the provisions of section 123115(b) provide for a very specific action.

Health and Safety Code section 123115(b) expressly forbids a health care provider who makes a medical determination that allowing a patient to view or copy the designated mental health record involves a substantial risk of significant adverse or detrimental medical consequences, from releasing the record to anyone other than a licensed physician or health care provider.

At the same time, due process requires that the evaluator's report, which made be used in a contested claim to determine the injured worker's entitlement to various benefits, must be made available to the injured worker, the injured worker's attorney, if any, and to the claims administrator, or if none the employer.

The proposed regulation is necessary to harmonize the provisions of Health and Safety Code § 123115(b) that prescribe a physician's actions regarding a mental health record subject to a medical determination pursuant to that section, and the Labor Code provisions that require service of a medical-legal evaluation report used to determine benefits on the injured worker.

After the second 15 day comment period, in response to comments, subdivision 36.5 was amended as follows for clarity, consistency and correct cross-reference:

Subdivision 36.5(b)(2) was amended to improve syntax and punctuation, without changing the meaning of the subdivision. In addition the phrase "or on the employee's attorney, if any" was added to the end of the subdivision.

Subdivision 36.5(b)(6) was amended to improve cross-reference by adding the phrase "with the QME Form 121 attached" in the last line of the subdivision.

Subdivision 36.5(b)(7) was amended to improve cross-reference by adding the phrase "with the document cover sheet, DWC-CA form 10232.1 (see, 8 Cal. Code Regs. § 10232.1), and separator sheet, DWC-CA form 10232.2 (see, 8 Cal. Code Regs. § 10232.2), as required by Title 8, California Code of Regulations section 10160(d)(4);"

Subdivision 36.5(d) was amended to correct cross-reference by replacing "36.5(a)(5), 36.5(a)(6) or 36.5(a)(7)" with 36.5(b)(6), 36.5(b)(7) or 36.5(b)(8)".

Subdivision 36.5(f) was amended to correct cross-reference by replacing "36.5(a)" with "36.5(b)".

Subdivision 36.5(g) was amended to improve syntax and for clarity without changing the meaning, to add the phrase "on the claims administrator, or if none on the employer." to the end of the first sentence and by starting the next sentence with the phrase "The evaluator shall serve the evaluation report with the QME Form 120 attached" before the words "by completing the questions and the declaration of proof of service on the QME Form 111(Qualified Medical Evaluator's Findings Summary Form)(See, 8 Cal. Code Regs. § 111). In the case of an unrepresented injured worker, the evaluator shall serve the report with the required forms as provided in subdivision 36.5(b)(7) of Title 8 of the California Code of Regulations."

Subdivision 36.5(h) was edited for clarity and to improve syntax.

Subdivision 36.5(i) was edited for clarity and consistency to replace the words "is not" with the words "shall not be" on line 2 of the subdivision.

Subdivision 36.5(j) was edited for clarity and to improve grammar by replacing the word "given" with the word "provided".

Subdivision 36.5(k) was edited, in response to comments, to improve clarity and is necessary to provide direction to an evaluator in the event the injured worker refuses or fails to designate a physician's in writing for use on QME Form 120 or QME Form 121 when serving the report.

The amendments made after the second 15 day comment period are (shown in underline):

(k) In the event the injured worker ~~declines or~~ refuses or fails to designate a physician in writing to be listed on either QME Form 120 or QME Form 121, the evaluator~~'s report~~ shall ~~be~~ serve~~d~~ the report as appropriate under section 36 or section 36.5, and within the time periods under section 38, of Title 8 of the California Code of Regulations, except that the injured worker's copy of the report which is subject to a finding under Health and Safety Code § 123115(b) shall then be served only on the injured worker's attorney, if represented, or if not represented on the injured worker's primary treating physician. ~~A non-mandatory Authorization for Release of Medical Information form is available as QME Form 125 (Authorization for Release of Medical Information). (See, 8 Cal. Code Regs. Section 125.)"~~

The addition of the phrase "…, except that the injured worker's copy of the report which is subject to a finding under Health and Safety Code § 123115(b) shall then be served only on the injured worker's attorney, if represented, or if not represented on the injured worker's primary treating physician" is necessary to harmonize the procedures in the workers' compensation system with the protections and procedures of Health and Safety Code § 123115(b). Where the evaluator is the first physician to make a determination under Health and Safety Code 123115(b), in regard to the

evaluation report not being served on the injured worker due to the significant detrimental impact, it is important that this medical opinion and determination be provided to the primary treating physician in order that appropriate medical follow up occur.

The Administrative Director's decision to delete the reference to the non-mandatory Authorization for Release of Medical Information form and to delete proposed section 125 and the proposed form are not substantive changes since the form and its use were merely optional.

§ 38. Medical Evaluation Time Frames; Extensions for QMEs and AMEs

The following modifications were made in response to comments received.

Subdivision 38(a) has been amended to provide that parties who elect to waive the untimeliness of completion and service of a medical/legal report may do so in writing or by use of QME Form 113 or QME Form 116. Subdivision 38(a) has also been amended to add "Agreed Panel QME" and "signing and returning to the Medical Director" for clarity.

Subdivision 38(d) provides that when the Medical Director sends the parties either QME Form 113 or QME Form 116 due to a late report, the form sent is to be used by each party to indicate their decision.

Subdivision 38 (h) was amended to add the phrase "and which were properly served on the opposing party as required by Labor Code section 4062.3".

Subdivision 38(h) was amended for clarity and consistency , to add after the words "An extension of the sixty (60) day…":

> "…time frame for completing the supplemental report, of no more than thirty (30) days, may be allowed without the need to request an extension from the Medical Director, as long as the evaluator contacts both parties at least fourteen (14) calendar days prior to the end of the sixty (60) day time frame and within seven (7) calendar days of being contacted, both parties agree to the extension in writing which is sent to the evaluator. Each party may send the evaluator their written agreement to the extension separately. However, if either party objects to the extension or if either party fails to respond to the evaluator at least seven (7) calendar days prior to the end of the sixty (60) day time frame, the evaluator must request the extension from the Medical Director by completing and submitting QME Form 112 (See, 8 Cal. Code Regs. § 112). The evaluator shall mail the completed QME Form 112 to the Medical Director no later than five (5) calendar days before the end of the sixty (60) day time frame above."

This text was added by the Administrative Director as required by Labor Code section 139.2(j)(1)(C).

However, in response to a comment received, after the second 15 day comment period, subdivision 38(h) was further edited for clarity, to delete the words after "…request an extension from the Medical Director" that described a process for obtaining party agreement, and now provides:

"(h) The time frame for supplemental reports shall be no more than sixty (60) days from the date of a written or electronically transmitted request to the physician by a party. The request for a supplemental report shall be accompanied by any new medical records that were unavailable to the evaluator at the time of the original evaluation and which were properly served on the opposing party as required by Labor Code section 4062.3. An extension of the sixty (60) day time frame for completing the supplemental report, of no more than thirty (30) days, may be agreed to by the parties without the need to request an extension from the Medical Director."

Subdivision 38(j) which was originally proposed during this rulemaking has been deleted.

§ 40. Disclosure Requirements: ~~Unrepresented~~ Injured Workers

The following modifications were made in response to comments received.

Subdivision 40(a)(2) has been amended to improve grammar and syntax, by adding the term "(A)" after the word "includes:" and:

"(B) abusive, hostile or rude behavior including behavior that clearly demonstrates a bias against injured workers, and (C)…"

§ 41. Ethical Requirements

The following modifications were made in response to comments received.

Subdivision 41(a)(7) was amended to provide that an evaluator shall refrain from "…unilaterally rescheduling a panel QME examination more than 2 times in the same case."

Subdivision 41(a)(8) was amended to replace "14 calendar days" with "six (6) business days" to conform to the time frames in section 34.

Subdivision 41(c)(2) was amended to add the sentence: "The report must list and summarize all medical and non-medical records reviewed as part of the evaluation."

Subdivision 41(c)(4) was amended to improve clarity and consistency to insert the words "claims administrator, or if none the" before the word "employer".

Subdivision 41(c)(7) was amended to delete the proposed new requirement that the consulting physician sign his or her report under penalty of perjury in compliance with Labor Code section 4628. The Administrative Director was concerned that errors by physicians who are not QMEs or AMEs in the workers' compensation system who are familiar with these requirements could lead to unnecessary litigation and delays. By simply requiring that the consulting physician's report be incorporated by reference and commented on by the referring evaluator who arranged the consultation, the requirements in the Labor Code to protect against ghost writing and fraud should be met.

Subdivision 41(c)(8) was added and provides: "(8) Serve the report at the same time as provided in these regulations on the employee and the claims administrator, or if none the employer, and on their attorneys, respectively."

The Reference notation was amended to add Labor Code Section "4062.5" to the list of sections.

§ 41.5 Conflicts of Interest by Medical Evaluators

The following modifications were made in response to comments received.

Subdivisions 41.5(c)(1) and 41.5(c)(6) were amended for consistency to replace "employee" with "worker".

Subdivision 41.5(c)(7) was added to provide:
"(7) Other purveyor of medical goods or medical services, only if the medical necessity for using such goods or services is in dispute in the case."

Subdivision 41.5(f) was amended for consistency to replace the word "employee" with "worker"; also to insert the phrase "claims administrator, or if none the" before the word "employer"; and finally to delete the word "insurer" as surplusage.

Subdivision 41.5(g) was amended for consistency to replace the word "employee" with "worker"; also to insert the phrase "claims administrator, or if none the" before the word "employer".

§ 41.6 Procedures after Notice of Conflict of Interest and Waivers of Conflicts of Interest of an Evaluator

The following modifications were made in response to comments received.

Subdivision 41.6(b) was amended to improve syntax and clarity as follows:

(b) An evaluator shall proceed with any scheduled evaluation involving a physical examination or ~~requested~~ supplemental report ~~needed~~ in the case, unless either the evaluator declines to ~~conduct~~ ***proceed*** ~~the evaluation or report~~ due to disqualifying himself or herself pursuant to section 41.5(e) of Title 8 of the California Code of Regulations or ***unless, pursuant to this section, the injured worker or the claims administrator*** ~~party~~ is entitled to a replacement QME ~~pursuant to this section~~.

Subdivisions 41.6(c)(1) and 41.6(c)(2) were amended for consistency to replace the word "employee" with "worker".

§§ 43 through 47 (Evaluation Guidelines – Various)

The following modifications were made in response to comments received. The phrase "claims

administrator, or if none the" was added before the word "employer", as appropriate.

§ 50. Reappointment: Requirements and Application Form

The following modifications were made in response to comments received.

Subdivision 50(b) was amended to improve grammar by deleting the words "Upon its" and replacing them with "As part of the".

Subdivision 50(c)(4), as proposed and pertaining to direct medical treatment at a primary practice location, was deleted for consistency. All other regulatory language regarding a 'primary practice location' was deleted from these regulations.

Subdivisions 50(c)(4) through (6) were added, to list the statements made on the reappointment application form under penalty of perjury:

"(4) attesting that the physician's license to practice as a physician, as defined under Labor Code section 3209.3, is neither restricted nor encumbered by suspension or probation, nor has the physician been convicted of a misdemeanor or felony related to the physician's practice or a crime of moral turpitude, and that the physician will notify the Administrative Director if the physician's license to practice is subsequently suspended or placed on probation or if the physician is convicted of a misdemeanor or felony related to the physician's practice or of a crime of moral turpitude; and

(5) attesting that the physician shall abide by all regulations of the Administrative Director and shall refrain from making referrals in violation of those regulations; and

(6) attesting that the physician has not performed a QME evaluation during a time when the physician was not appointed as a QME."

§ 55. Reappointment: Continuing Education Programs

The following modifications were made in response to comments received.

Subdivision 55(d) was amended for consistency, to add "an education" before the word "provider". Also, after the second 15 day comment period, the subdivision was also amended to correct a cross reference to subdivision 1(q), the definition of an "education provider".

§ 57. Reappointment: Professional Standard – Violation of Business and Professions Code Section 730

Section 57 was amended for consistency to replace the word "employee" with the word "worker".

§ 60. Discipline

After the second 15 day period, a cross reference in subdivision 60(c)(10) was corrected from "1(ee)" to "1(cc)" for the definition of "significant financial interest".

Minor capitalization corrections were made in subdivision (d).

§ 65. Sanction Guidelines for Qualified Medical Evaluators

The following modifications were made in response to comments received.

The section heading numbering and lettering system, used in the guidelines from PART ONE through PART THREE, was made consecutive and consistent, for clarity and ease of cross-reference. In addition, some section headings were re-worded for clarity.

The following text was added to the list of types of evaluation report deficiencies that could result in discipline after three or more instances are established in "16. Report Deficiencies:"

> "-Other report deficiencies that affect the substantial rights of a party and are in violation of the regulations governing QMEs;"

§ 100. The Application for Appointment as Qualified Medical Evaluator Form.

The following modifications were made in response to comments received.
On page 2, block 5, item one, the following phrase was added to the statement used by applicant Ph.D.'s: "and have five (5) or more years of post doctoral experience."

Page 4 block 10, paragraph A and B: the word "California" was inserted before the word "license".

Page 4, block 10, paragraph C, the declaration statement about spending 5 or more hours per week in direct patient treatment at each primary practice location, has been deleted.

On page 6, which lists QME specialty codes, the following corrections have been made:

"MTT" has replaced the code MPT for General Preventive Medicine-Toxicology in order that all physicians who are certified specialists in toxicology will be listed under this code.
MOS now reads "Orthopaedic Surgery (other than Spine or Hand)" for those orthopaedic surgeons who do not wish to evaluate spine or hand injuries.
MPS now reads "Plastic Surgery (other than Hand)" for those surgeons who do not wish to evaluate spine or hand injuries.
MPD now reads "Psychiatry (other than Pain Medicine)" for those psychiatrist who do not wish to evaluate disputes involving pain problems.
"MPA Psychiatry – Pain Medicine" is added for those psychiatrists who wish to evaluate disputes involving pain problems.
MSY now reads "Surgery (other than Spine or Hand)".
The codes for Pediatrics (MEP) and Pediatrics – Allergy & Immunology (MAI) are being deleted because there are no such QMEs at this time and since injured workers who are under 21 can be sent to the appropriate specialist in any event.

§ 103. The QME Fee Assessment Form.

The following modifications were made in response to comments received.

All text referring to or pertaining to "primary practice locations" has been deleted.

§ 104. The Reappointment Application as Qualified Medical Evaluator Form.

The following modifications were made in response to comments received.

On page 3, block 5, the first paragraph has been amended to read:

"Affirmations: (Initialing each box affirms that you have read and agree to each of the statements. **Do not initial if your statement is untrue; attach explanation on a separate piece of paper. Failure to do so may result in disciplinary action by the Administrative Director.**"

Also, the word "California" has been inserted before the word "license" in paragraphs A and B.

In paragraph C in block 5, the sentence pertaining to hours spent at a "primary practice location" has been deleted.

On page 5, which lists QME specialty codes, the following corrections have been made:

"MTT" has replaced the code MPT for General Preventive Medicine-Toxicology.

MOS now reads "Orthopaedic Surgery (other than Spine or Hand)".
MPS now reads "Plastic Surgery (other than Hand)".
MPD now reads "Psychiatry (other than Pain Medicine)".
"MPA Psychiatry – Pain Medicine" is added for those psychiatrists who wish to evaluate disputes involving pain problems.
MSY now reads "Surgery (other than Spine or Hand)".
The codes for Pediatrics (MEP) and Pediatrics – Allergy & Immunology (MAI) are being deleted because there are no such QMEs at this time and since injured workers who are under 21 can be sent to the appropriate specialist in any event.

§ 105. The Request for Qualified Medical Evaluator Panel - Unrepresented ~~Instruction~~ Form and Attachment to Form 105 (How to Request a QME If You Do Not Have an Attorney).

In response to comments received and to facilitate more expedient processing of QME panel requests in unrepresented cases, the form was changed.

In addition to formatting changes and minor wording changes, after the first 15 day comment period, the following new items were added. The additional text will assist the Medical Unit in

determining whether a panel may be issued without sending the request back to the requestor for additional information.

This form has been revised to add new questions, including has any body part in this claim been accepted, has this claim been denied, did notice to the injured employee state employer requests an evaluation to determine compensability. The descriptions of the reasons for requesting a panel, as stated on the form, have been reworded to separate and distinguish the choices allowed an injured worker seeking an evaluation under Labor Code section 4062 and the choices allowed a claims administrator, or if none the employer, under Labor Code section 4062 in light of the California Supreme Court in State Compensation Insurance Fund v. Workers' Compensation Appeals Board and Brice Sandhagen (2008) 44 Cal. 4th 230, 186 P. 3d 535; 79 Cal.Rptr. 171; 73 Cal.Comp.Cases 981 (hereafter, Sandhagen). In that decision, the Court held that only an employee, and not the employer, may obtain a medical-legal evaluation to address a dispute regarding medical treatment.

After the first 15 day comment period, the formatting and appearance of the form was changed to make the form readable by an optical character reviewer (OCR) as required by newly adopted regulations of the Court Administrator as part of the EAMS (Electronic Adjudication Management System) project, and as set out in sections 10210 *et seq* of Title 8 of the California Code of Regulations.

Necessity: Labor Code section 4060(a) provides that section 4060 shall not apply if any part of a workers' compensation claim has been accepted. The attachment to Form 105 explains that the party must select a different reason for requesting a panel in such a case.

"Is disputed about MPN: ___ Continuity or Transfer of Care ____Permanent Disability, Future Medical, UR decision_____ Diagnosis or Treatment"

Necessity: Labor Code section 4614.3(c) provides that when the injured employee disputes the MPN physician's diagnosis or treatment opinion, the injured worker must obtain a second or third opinion from another physician within the MPN, rather than from a QME or AME. When the dispute involves one or more of the other reasons (continuity or transfer of care; permanent disability; future medical treatment; utilization review decision), even when the injured worker receives medical treatment through an MPN, those disputes may be the basis for obtaining a QME panel.

Section on "Prior QME Panel Information": All of the questions in this section pertain to information the Medical Unit needs to have whenever a panel request is received but the QME database system indicates a QME panel has already been issued to the injured worker for this date of injury. Once a panel is issued, the Medical Unit does not receive further information about whether it was used or which QME may have been selected. Currently, the Medical Unit must send a letter requesting this additional information which creates delays in issuing a panel. The parties can reduce the likelihood of delay by providing this information on the form, if it is known, at the time of making the initial panel request.

Page 2 of QME Form 105 (specialty codes);

"MTT Emergency Medicine – Toxicology" is deleted as all physicians with certified specialties in Toxicology will be included under MTT Toxicology, which also is on the list.

"MHH Hand" deletes the words "orthopaedic surgery" because this code will include hand specialists from orthopedic surgery, general and plastic surgery.

"MNB Spine" deletes the words "orthopaedic surgery and neurological surgery" because both types of specialists would be qualified to evaluate spine injuries and this category would be selected by physicians in these two specialties who specifically want to evaluate spine injuries.

"MNS Neurological Surgery" adds the words "(other than Spine)" to distinguish those neurological surgeons who do not wish to evaluate spine injuries.

"MMO Oncology – Orthopaedic Surgery, Internal Medicine or Radiology" simply reduces the redundancy in the descriptor.

"MOS Orthopaedic Surgery (other than Spine or Hand)" is a re-worded descriptor to be used by those orthopaedic specialists who do not wish to evaluate spine or hand injuries.

"MPS Plastic Surgery (other than Hand)" is meant for those plastic surgeons who do not wish to evaluate hand injuries.

"MPD Psychiatry (other than Pain Medicine)" is meant for those cases requiring a psychiatrist for injuries other than pain injuries.

"MSY Surgery (other than Spine or Hand)" is for those general surgery specialist who do not wish to evaluate spine or hand injuries.

"MTT – Toxicology" will include all medical doctors and osteopaths with certified specialties in toxicology, whether obtained through emergency medicine, general preventive medicine or occupational medicine.

The Attachment to QME Form 105 – How to Request a QME if You Do Not have an Attorney:

The text of this document was completely re-edited for clarity and to delete material that was duplicative of the information provided to an injured worker in QME form 108.

After the second 15 day comment period, minor edits were made to the form to add the word "required" under lines that must have the information entered. In addition a check box for "Defense Attorney" was added at the top right of the form. This is necessary for the Medical Unit staff as a visual cue to look for the attorney's contact information on any cover letter attached to the form, in order that it may be entered into the QME database and so the attorney receives a copy of the QME panel when it is issued.

The line pertaining to MPN related disputes was re-worded.

The word "California" was inserted in front of the word "zip code in which you would like to be evaluated:" for clarity.

Capitalization errors were corrected on the second page.

The words "signed by" were replaced with "signature of injured employee". The phrase "print name of requestor" was entered under the line 'requested by:'

The revision date on the bottom of the form was changed to Feb. 2009.

§ 106. The Request for Qualified Medical Evaluator Panel – Represented Form and Attachment to Form 106 (How to Request a QME in a Represented Case)

The changes to QME Form 106 are substantially the same as those made to QME Form 105. In response to comments received and to facilitate more expedient processing of QME panel requests in represented cases, the form has been changed.

In addition to formatting changes and minor wording changes, the following new items were added. The additional text will assist the Medical Unit in determining whether a panel may be issued without sending the request back to the requestor for additional information.
A box for disputes under both section 4061 and 4062 has been added at the top.

This form has been revised to add new questions, including has any body part in this claim been accepted, and has this claim been denied. A reminder to attach a copy of the earliest written AME offer that identifies disputed issue and names one or more physicians has also been added. The descriptions of the reasons for requesting a panel, as stated on the form, have been reworded to separate and distinguish the choices allowed an injured worker seeking an evaluation under Labor Code section 4062 and the choices allowed a claims administrator, or if none the employer, under Labor Code section 4062 in light of the California Supreme Court in State Compensation Insurance Fund v. Workers' Compensation Appeals Board and Brice Sandhagen (2008) 44 Cal. 4th 230, 186 P. 3d 535; 79 Cal.Rptr. 171; 73 Cal.Comp.Cases 981 (hereafter, Sandhagen). In that decision, the Court held that only an employee, and not the employer, may obtain a medical-legal evaluation to address a dispute regarding medical treatment.

Necessity: Labor Code section 4060(a) provides that section 4060 shall not apply if any part of a workers' compensation claim has been accepted. The attachment to Form 105 explains that the party must select a different reason for requesting a panel in such a case.

"Is disputed about MPN: ___ Continuity or Transfer of Care ____Permanent Disability, Future Medical, UR decision_____ Diagnosis or Treatment"

Necessity: Labor Code section 4614.3(c) provides that when the injured employee disputes the

MPN physician's diagnosis or treatment opinion, the injured worker must obtain a second or third opinion from another physician within the MPN, rather than from a QME or AME. When the dispute involves one or more of the other reasons (continuity or transfer of care; permanent disability; future medical treatment; utilization review decision), even when the injured worker receives medical treatment through an MPN, those disputes may be the basis for obtaining a QME panel.

Section on "Prior QME Panel Information": All of the questions in this section pertain to information the Medical Unit needs to have whenever a panel request is received but the QME database system indicates a QME panel has already been issued to the injured worker for this date of injury. Once a panel is issued, the Medical Unit does not receive further information about whether it was used or which QME may have been selected. Currently, the Medical Unit must send a letter requesting this additional information which creates delays in issuing a panel. The parties can reduce the likelihood of delay by providing this information on the form, if it is known, at the time of making the initial panel request.

Page 2 of QME Form 106 (specialty codes):

"MTT Emergency Medicine – Toxicology" is deleted as all physicians with certified specialties in Toxicology will be included under MTT Toxicology, which also is on the list.

"MHH Hand" deletes the words "orthopaedic surgery" because this code will include hand specialists from orthopedic surgery, general and plastic surgery.

"MNB Spine" deletes the words "orthopaedic surgery and neurological surgery" because both types of specialists would be qualified to evaluate spine injuries and this category would be selected by physicians in these two specialties who specifically want to evaluate spine injuries.

"MNS Neurological Surgery" adds the words "(other than Spine)" to distinguish those neurological surgeons who do not wish to evaluate spine injuries.

"MMO Oncology – Orthopaedic Surgery, Internal Medicine or Radiology" simply reduces the redundancy in the descriptor.

"MOS Orthopaedic Surgery (other than Spine or Hand)" is a re-worded descriptor to be used by those orthopaedic specialists who do not wish to evaluate spine or hand injuries.

"MPS Plastic Surgery (other than Hand)" is meant for those plastic surgeons who do not wish to evaluate hand injuries.

"MPD Psychiatry (other than Pain Medicine)" is meant for those cases requiring a psychiatrist for injuries other than pain injuries.

"MSY Surgery (other than Spine or Hand)" is for those general surgery specialist who do not wish to evaluate spine or hand injuries.

"MTT – Toxicology" will include all medical doctors and osteopaths with certified specialties in toxicology, whether obtained through emergency medicine, general preventive medicine or occupational medicine.

The attachment to QME Form 106 was substantially re-edited. The text as presented now is the proposed final text if no further modifications are made.

After the first 15 day comment period, the formatting and appearance of the form was changed to make the form readable by an optical character reviewer (OCR) as required by newly adopted regulations of the Court Administrator as part of the EAMS (Electronic Adjudication Management System) project, and as set out in sections 10210 *et seq* of Title 8 of the California Code of Regulations.

After the second 15 day comment period, minor edits were made to the form to add the word "required" at lines that must have the information entered.
The line pertaining to MPN related disputes was re-worded.

The word "California" was inserted in front of the word "zip code in which you would like to be evaluated:" for clarity.

Capitalization errors were corrected on the second page.

The words "signed by" were replaced with "signature of injured employee". The phrase "print name of requestor" was entered under the line 'requested by:'

The revision date on the bottom of the form was changed to February 2009.

§ 107. The Qualified Medical Evaluator Panel Selection Form.

The following modifications were made in response to comments received.

A box for disputes under both section 4061 and 4062 has been added at the top after type of exam.

The words "Ins. Adj/Agency" were deleted and replaced with "Claims Administrator".

§ 108. The Qualified Medical Evaluator Panel Selection Instruction Form.

The following modifications were made in response to comments received.

Minor wording changes have been made throughout for clarity.

The wording in the choices under item 2, regarding when the injured employee may wait beyond 60 days for the evaluator to have an available appointment, has been changed to be consistent with the wording in section 34 of Title 8 of the California Code of Regulations and Labor Code section 139.2(j)(1)(C). Also, the order of the choices was changed. The word "adjuster" was replaced with "administrator" in item 4.

Item 6, a sentence was added that provides: "You may send the QME a letter listing the disputed medial issues you believe the evaluator should address in your claim." This is allowed under section 35 of Title 8 of the California Code of Regulations and Labor Code section 4062.3.

Item 8, a sentence was added: "The panel is assigned and mailed on the same date, which is shown as the 'Date Mailed' on the top right side of the QME panel letter, QME Form 107 (See, 8 Cal. Code Regs. 107)."

After the second 15 day comment period, in response to a comment, the phrase "at least" was deleted from item a). on the form, for clarity.

§ 109. The ~~Notice of~~ Qualified Medical Evaluator Notice of Unavailability Form.

The following modifications were made in response to comments received.
The words "AME or" were deleted from the Note paragraph at the bottom of the form.

§ 110. The Appointment Notification Form.

The following modifications were made in response to comments received.

The words "Insurer or" in the title of the third section was deleted for clarity.

The word "or" was deleted and replaced with "and" after the boxes for showing copies were sent to the Employee and the Claims Administrator at the bottom of the form above the signature line. The words "if known" at the same spot were deleted.

Text was added to the instructions paragraph addressed to the evaluator, consistent with the applicable regulations, that provides:

"You also must use this form if you refer the injured worker for a consultation to advise the parties of the date and time of the appointment with the consulting physician (See, 8 Cal. Code Regs. Section 32). You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, Cal. Code Regs. Section 34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, Cal. Code Regs. Sections 34 and 41(a)(7) and (a)(8))."

§ 111. The Qualified ~~or Agreed~~ Medical Evaluator's Findings Summary Form.

The following modifications were made in response to comments received.

The title is being changed for clarity. This form has been revised to clarify that it is only required to be used when the QME is evaluating an unrepresented injured worker and the report addresses permanent impairment or permanent disability.

The words "or Agreed" have been deleted from the title of the form. "Unrepresented Injured Employee Cases Only" has been inserted below the form title to clarify when it is to be used.

In block 2, the word "/Employer" has been deleted for clarity.

In block 3, the word "AME/" has been deleted for clarity. The form should not be used by any AME.

In block 4, the word "patient's" is deleted and replaced with "injured employee's". The word "benefits" has been added at the end of the sentence, for clarity.

In block 5, under Basis for Conclusions, questions 16, new text was added as follows:
"(For non-psyche injuries)"
"(For psyche injuries) the GAF and 2005 PD Schedule?"

This new text was needed to distinguish between the basis for permanent impairment ratings, depending on nature of the injury, as provided in the Labor Code and the permanent disability rating schedule adopted by the Administrative Director effective January 1, 2005.

After the second 15 day comment period, in block 2, the spelling of the word "Administrator" was corrected.

In block 3, item 12, the wording was changed for clarity and to remove ambiguity, as follows:
"12.A. Date this QME report served on all parties:" and "12.B. Date(s) of all Prior Reports Served by this QME:"

Page 2: The following questions have been added:

"22. Are there any unresolved disputed issues beyond the scope of our licensure or clinical competence that should be address by an evaluator in a different specialty - Yes….No…."
23. If the answer to # 22 is yes, what disputed issue(s)?"
24. Based on the answer in # 23, what specialty (or specialties)?"

Necessity: These questions are added to the form to enable the panel QME to advise the parties that another QME in a different medical specialty is needed to address issues out of the medical scope of practice or clinical competence of the panel QME. A paragraph has been added to the instruction page, page 3 of this form, that explains when this may be appropriate pursuant to Labor Code section 4062.3.

Labor Code section 4062.3(i) provides:

"Upon completing a determination of the disputed medical issue, the medical evaluator shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator."

Where a disputed issue is outside the scope of the evaluator's medical license or clinical competence, the evaluator must communicate that to the parties in order that a physician in the appropriate specialty may be obtained to address those outstanding issues. The Medical Unit needs some evidence from the evaluator and the parties when this occurs. By answering these questions, the parties are provided with a statement under penalty of perjury by the evaluator, which may be used as supporting evidence for a request for an additional QME panel in a different medical specialty as addressed in proposed section 31.7 of Title 8 of the California Code of Regulations.

The Declaration of Service of Medical/Legal Report (Lab. Code 4062.3) has been revised for clarity.

Page 4, the Instruction Form. The words "or AME" are deleted as the form is not to be used by AMEs. In addition, text was added to parts of the instruction page for clarity, to be consistent with the applicable regulations in Title 8.

A paragraph has been added:

"Need for Additional Evaluation in Another Specialty: Labor Code section 4062.3 directs each evaluator to address all contested medical issues arising from all injuries reported on one or more claim forms prior to the evaluator's initial evaluation. Each evaluator is expected to address permanent impairment consistent with the AMA guides for the evaluator's specialty, or for disputed injuries to the psyche consistent with the global assessment of functioning (GAF) as directed in the 2005 Permanent Disability Schedule adopted by the Administrative Director effective 1/1/2005. . In the event there are contested medical issues outside of the scope of your licensure or clinical competence that require evaluation by a physician in a different specialty, complete the information required in questions 22 through 24, and serve a copy of your report on the Medical Unit of DWC."

Additional minor, non-substantive edits were made to the instructions for clarity.

§ 112. The ~~Qualified or Agreed Medical Evaluator~~ QME/AME Time Frame Extension Request Form.

The following modifications were made in response to comments received.
The word "adjuster" is deleted and is being replaced with "administrator".
The words "employer/insurer" are deleted in the paragraph of instructions at the bottom of the form.
A check box was added for "Request extension for supplemental report."
A reference was added in the instructions paragraph to section 34(h) of Title 8 of the California

Code of Regulations regarding extensions of supplemental reports.

After the second 15 day comment period, the form was amended to correct the cross-reference from 34(h) to "38(h)".

§ 113. ~~The Time Extension Approval Form~~. Notice of Denial of Request for Time Extension Form.

The following modifications were made in response to comments received.
The words "adjuster/employer" are deleted and are being replaced with the word "administrator" after the word "claims".
The words "Agreed Panel QME" and "AME" were added as needed for clarity.
Other minor edits are made for clarity.

§ 116. ~~The Notice of Late Qualified Medical Evaluator Report Form-Extension Not Requested Form~~. Notice of Late QME/AME Report – No Extension Requested Form.

The following modifications were made in response to comments received.
The words "adjuster/employer" are deleted and are being replaced with the word "administrator" after the word "claims".
The words "Agreed Panel QME" and "AME" were added as needed for clarity.
Other minor edits are made for clarity.

§ 117, 118 and 119:
The following modifications were made in response to comments received.
Only the form revision date has been changed to "June 2008".

§ 120. Voluntary Directive for Alternate Service of Medical-Legal Evaluation Report on Disputed Injury to Psyche.

The following modifications were made in response to comments received.

The two options for the injured worker to select from now read:

"___ By sending my copy to the following physician who will review it with me and will be paid for an office visit for this purpose by the claims administrator, or if none the employer. The physician I name below can be my primary treating physician in this case or any other physician I wish to designate. At the end of that visit, the physician below will give me my copy of the report:"

___ Only by sending a copy to me at my address on file. I do not wish to have a physician review it with me."

The word "named" was added to one of the choices. Other minor wording edits and additions were made for clarity.

§ 121. Declaration Regarding Protection of Mental Health Record.

This form is new and being proposed for the first time for use by an evaluator who makes a determination under Health and Safety Code section 123115(b). The necessity for this form and this procedure is discussed more fully under the discussion of section 36.5, above.

§ 122. AME or QME Declaration of Service of Medical-Legal Report.

This new form must be used by AMEs and panel QMEs in represented cases when serving any medical/legal report. In unrepresented cases, this form must be used by a panel QME when serving a medical/legal report except when QME Form 111 is used.
A heading naming this agency was added to the form. Other minor wording edits were made for clarity.

Necessity: Labor Code section 4062.3(i) requires all evaluators to serve a copy of the medical/legal evaluation report once completed. This declaration of proof of service of a medical/legal report provides the evaluator with the necessary language to demonstrate compliance with this requirement.

§ 123. QME/AME Conflict of Interest Disclosure and Objection or Waiver by Represented Parties Form.

The following modifications were made in response to comments received.

On page 1, the words "Employer/Insurer/TPA" were deleted and replaced by the words "Claims Administrator".

On page 2, sentence 1 was edited for clarity and now reads:
A QME or AME who knows, or should know, that he or she has a disqualifying conflict of interest as defined in section 41.5 of Title 8 of the California Code of Regulations, with any person or entity listed in subdivision 41.5(c), that also is involved in the case the evaluator is handling, must notify the parties in writing of the conflict of interest."

The following sentence is added to the summary of definitions under section 41.5 of Title 8 of the California Code of Regulations:
"Other purveyor of medical goods or medical service, only if the medical necessity for using such goods/services is disputed."

§ 124. Specified Financial Interest Attachment to QME Forms 100, 103 or 104 ("SFI Form 124").

The following modification was made for clarity. This text was added to the bottom of the form:

"* "Specified Financial Interests" means being a general partner or limited partner in, or having an interest of 5 percent of more, or receiving or being legally entitled to receive a share of 5% or more of the profits from, any medical practice, group practice, medical group, professional corporation, limited liability corporation, clinic or other entity that provides treatment or medical evaluation goods or services for use in the California workers' compensation system (8 Cal. Code Regs. § 29(b).)"

§ 125. Authorization for Release of Medical Information.

Section 125 was added as a new section and a new, non-mandatory form for use by evaluators performing evaluations involving injuries to the psyche, as provided in section 36.5(k) of Title 8 of the California Code of Regulations, discussed above. It provides:

> "The use of this form by an Agreed Medical Evaluator, Agreed Panel QME or Qualified Medical Evaluator is optional, as provided in section 36.5 of Title 8 of the California Code of Regulations.
>
> NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.
>
> Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 56 through 56.37, Civil Code; Sections 4060, 4061, 4062, 4062.1, 4062.2, 4064, 4067, Labor Code."

As section 36.5(k) states, use of this form by evaluators is not mandatory, although it is recommended in circumstances described in that subdivision, when the injured worker wants the evaluation report to be served directly on the injured worker and declines or refuses to designate a physician upon whom to serve the report for the purpose of discussing and reviewing its contents with the injured worker.

The Administrative Director believes this section will assist evaluators to address the complex medical issues that may arise in connection with a medical-legal evaluation of a disputed injury to the psyche. The language in 36.5(k) and form proposed in section 125 enable the injured worker's desires regarding service of the report to be fulfilled. The form provides the evaluator with an authorization for release of medical information for the content of the evaluation report, in order that the evaluator not be subjected to unnecessary litigation for alleged violations and disputed legal interpretations about the interplay between workers' compensation law and the Confidential of Medical Information Act (Civ. Code sections 56 *et seq*)

However, after the second 15 day comment period, in response to a comment, the Administrative Director decided to withdraw and delete this optional form and the proposed regulatory language that referred to it. Since the form was optional, this is a non-substantive change to the proposed regulations.

NON SUBSTANTIVE CHANGES MADE AFTER COMMENT PERIODS:

§ 30. QME Panel Requests

In subdivision 30(g), after the second 15 day public comment period the phrase ", any other person…" was inserted after "party's attorney", for clarity and to avoid confusion caused by ambiguity that a friend or volunteer of a party or their attorney might be allowed to deliver the panel request to the Medical Unit.

After the second 15 day public comment period the phrase ", any other person…" was inserted after "party's attorney", for clarity and to avoid confusion caused by ambiguity that a friend or volunteer of a party or their attorney might be allowed to deliver the panel request to the Medical Unit.

A new subdivision 30(h), which previously was the last sentence of subdivision 30(c), was added:

> "(h) The time periods specified in Labor Code sections 4062.1(c) and 4062.2(c), respectively, for selecting an evaluator from a QME panel and for scheduling an appointment, shall be tolled whenever the Medical Director asks a party for additional information needed to process the panel request. These time periods shall remain tolled until the date the Medical Director issues either a new QME panel or a decision on the panel request."

In response to a comment received during the second 15 day comment period, and for clarity, the Administrative Director substituted the word "resolve" with the word "process".

§ 32. Consultations

After the second 15 day comment period, the following sentence was added to subdivision 32(f) for clarity and consistency with the requirements in Labor Code 4062.3(d): "The referring evaluator shall list, in the report commenting on the consulting physician's report, all reports and information received from each party for the consulting physician, indicate whether each item was forwarded to the consulting physician, and for the items not forwarded the reason the referring evaluator determined it was necessary to forward the item to the consulting physician." This language clarifies that, as required under Labor Code section 4062.3(d), the referring evaluator must identify all reports reviewed and relied upon, and otherwise ensures each party is able to challenge the evaluation report if a medical record or history relevant to the disputed injury has been considered.

§ 34. Appointment Notification and Cancellation

In response to comments received during the second 15 day comment period on subdivision 34(f), the Administrative Director amended it to:

"(f) An Agreed Medical Evaluator who cancels a scheduled appointment shall reschedule the appointment within sixty (60) calendar days of the date of the cancellation unless the parties agree in writing to accept an appointment date no more than thirty (30) calendar days beyond the sixty (60) day limit."

In response to comments from psychiatrists and psychologists during the second 15 day comment period, the Administrative Director amended subdivision 34(g) to add after "appointment" in the existing sentence: "…unless the evaluator is a psychiatrist or psychologist performing an evaluation regarding a disputed injury to the psyche who states in the evaluation report that receipt of relevant medical records prior to the evaluation was necessary to conduct a full and fair evaluation."

§ 35. Exchange of Information and Ex Parte communications

After the second 15 day comment period, the Administrative Director amended subdivision 35(a), for clarity and consistency, to delete the phrase "Except as provided in subdivision 35(m) below,". Subdivision 35(m), as proposed after the first 15 day comment period, would have extended the provisions of regulation 35, regarding exchange of information and ex parte communications, to consulting physicians. The Administrative Director, instead, determined it would be more consistent with the existing practice regulated by subdivision 32 of Title 8 of the California Code of Regulations, to instead have the parties communicate through the selected QME rather than directly with the consulting physician. Consulting physicians may provide an evaluator with essential specialized medical knowledge on a consulting basis, but often are not certified QMEs and are unfamiliar with the requirements of the rules governing QMEs and the workers' compensation system. Accordingly, the Administrative Director deleted the proposed subdivision 35(m), added clarifying language on the issue of communications for the consulting physician in subdivision 32, and therefore is now deleting this reference to subdivision 35(m) in the introductory clause of 35(a).

After the second 15 day comment period, in response to comments received and for consistency with Health and Safety Code section 123115(b), the following sentence was added to subdivision 35 (c) as a new second sentence, followed by the remainder of the subdivision as quoted above:

"Mental health records that are subject to the protections of Health and Safety Code section 123115(b) shall not be served directly on the injured employee, but may be provided to a designated health care provider as provided in section 123115(b)(2), and the injured employee shall be notified in writing of this option for each such record to be provided to the evaluator."

The Administrative Director determined this added sentence is necessary since Health and Safety Code section 123112(b) specifically prohibits a physician from providing a mental health record subject to a determination made under that section to the patient or person about whom the mental health record pertains. This added language makes clear for the regulated parties the procedure to be followed in such an instance for such a record.

After the second 15 day comment period, the Administrative Director substituted the word "evaluator" for the words "QME or AME". This was a non-substantive change made for consistency in subdivision 35.5(e).

After the second 15 day comment period, and in response to comments received at that time, the wording was further amended by the Administrative Director for clarity, to provide:

> (f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and, upon the request of the unrepresented injured worker and whenever consistent with Labor Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed, or at a facility or office chosen by the deposing party that is not more than 20 miles from the location of the evaluation examination."

§ 36. ~~Summary Form for Comprehensive Medical-Legal Evaluation Performed Pursuant to Labor Code Section 4061 by QMEs or AMEs; Service of Form and Evaluation~~ Service of Comprehensive Medical-Legal Evaluation Reports by Medical Evaluators Including Reports Under Labor Code section 4061

After the second 15 day public comment period, the phrase "…with the document cover sheet, DWC-CA form 10232.1 (see, 8 Cal. Code Regs. § 10232.1), and separator sheet, DWC-CA form 10232.2 (see, 8 Cal. Code Regs. § 10232.2), as required by Title 8, California Code of Regulations section 10160(d)(4),…." was inserted in subdivision 36(c) for clarity, consistency and cross-reference. These references specify the newly adopted forms any person must use when filing a document at a DEU office, pursuant to 8 Cal. Code Regs. §§ 10160 and 10232 *et seq*. As the note section below subdivision 36 states, the forms referred to in this phrase are available to evaluators and to the public at no charge on the Division's website.

After the second 15 day comment period, and in response to comments received at that time, the wording was further amended by the Administrative Director for clarity, to provide:

> (f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and, upon the request of the unrepresented injured worker and whenever consistent with Labor Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed, or at a facility or office chosen by the deposing party that is not more than 20 miles from the location of the evaluation examination."

§ 36.5 Service of Comprehensive Medical/Legal Report in Claims of Injury to the Psyche

After the second 15 day comment period the wording in subdivision 36.5(a) was edited in response to comments, as follows for clarity and to improve syntax, without changing the meaning or obligations of the subdivision as previously proposed (changes shown by underlining):

> "(a) For any evaluation involving a claimed or disputed injury to the psyche, the injured worker shall be advised by the evaluator that the employee's copy of the comprehensive medical-legal report, and any follow up or supplemental reports, from the evaluation may be served either directly on the injured worker or instead on a physician designated in writing by the injured worker prior to leaving the evaluator's office, for the purpose of reviewing and discussing the evaluation report with the injured worker. The evaluator shall explain that the designated physician may be but need not be the injured worker's primary treating physician in the workers' compensation claim and that the employer will be responsible for payment for one office visit with the designated physician for this purpose.:

Changes to Sections 100 through 124 (QME Forms)

The revision date at the bottom of each form has been changed to "February 2009". In addition, the non-substantive changes discussed below have been made.

§ 105. The Request for Qualified Medical Evaluator Panel - Unrepresented ~~Instruction~~ Form and Attachment to Form 105 (How to Request a QME If You Do Not Have an Attorney).

After the second 15 day comment period, minor edits were made to the form to add the word "required" under lines that must have the information entered. In addition a check box for "Defense Attorney" was added at the top right of the form. This is necessary for the Medical Unit staff as a visual cue to look for the attorney's contact information on any cover letter attached to the form, in order that it may be entered into the QME database and so the attorney receives a copy of the QME panel when it is issued.

§ 106. The Request for Qualified Medical Evaluator Panel – Represented Form and Attachment to Form 106 (How to Request a QME in a Represented Case)

After the second 15 day comment period, minor edits were made to the form to add the word "required" at lines that must have the information entered.
The line pertaining to MPN related disputes was re-worded.

§ 108. The Qualified Medical Evaluator Panel Selection Instruction Form.

In 2(a), the words “at least” are removed for clarity and to remove ambiguity.

§ 111. The Qualified ~~or Agreed~~ Medical Evaluator’s Findings Summary Form.

The typographical error in “Claims Administrator” has been corrected.

In block 3, the word “AME/” has been deleted for clarity. The form should not be used by any AME. A line stating “Date(s) of all prior reports served by this QME” has been added for clarity.

In the instructions, under “Event Dates,” “date report” is changed to “dates reports.”

§ 112. The ~~Qualified or Agreed Medical Evaluator~~ QME/AME Time Frame Extension Request Form.

Following the words: “Request extension for supplemental report,” the words “(maximum 30 days)” are added for clarity.

After the second 15 day comment period, the form was amended to correct the cross-reference from 34(h) to “38(h)”.

§ 120. Voluntary Directive for Alternate Service of Medical-Legal Evaluation Report on Disputed Injury to Psyche.

The first check box is revised to state: “By sending my copy to the following physician who will review it with me and will be paid for an office visit for this purpose by the claims administrator, or if none by my employer. The physician I name below may be my primary treating physician in this case or any other physician I wish to designate. At the end of that visit, the physician named below will give me my copy of the report.” The two changes, having the “claims administrator” words retained and changing “can” to “may” are made for clarity purposes.

§ 121. Declaration Regarding Protection of Mental Health Record.

On page two, after Medical License, the words “if known” are added for clarity. I comma is added in the second option under number 7.

§ 125. Authorization for Release of Medical Information.

Section 125, which was added as a new section and a new, non-mandatory form for use by evaluators performing evaluations involving injuries to the psyche, as provided in section 36.5(k) of Title 8 of the California Code of Regulations, has been withdrawn as a regulation.

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed amendments do not apply to any local agency or school district.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective as and less burdensome to affected private persons and businesses than the regulations that were adopted.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the charts contained in the rulemaking binder.

The public comment periods were as follows:

- First 15 day comment period: June 25, 2008 through July 10, 2008.
- Second 15-day comment period: October 15, 2008 through November 6, 2008.

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